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ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature – Second Regular Session

COMMITTEE ON HEALTH

Report of Regular Meeting
Tuesday, February 9, 2016
House Hearing Room 4 -- 2:00 p.m.

Convened 3:40 p.m.
Recessed
Reconvened
Adjourned 6:17 p.m.

Members Present
Mr. Boyer
Mr. Friese
Mr. Lawrence
Mr. Meyer
Mrs. Cobb, Vice-Chairman
Mrs. Carter, Chairman

Members Absent

Agenda
Original Agenda – Attachment 1

Request to Speak
Report – Attachment 2

Presentations

Name	**Organization**	**Attachments** (Handouts)
Cara Christ, MD, MS	Director, Arizona Department of Health Services	
Susan E. Swedo, MD	Pediatrics & Developmental Neuroscience Branch, NIMH, NIH Intramural Program, Bethesda, MD	3
Floribella Redondo	President, Arizona Community Health Worker Association	4
Susan Kunz	Director of Health and Wellness, Mariposa Community Health Center	

Committee Action

Bill	**Action**	**Vote**	**Attachments** (Summaries, Amendments, Attendance)
HB2309	DPA	5-0-0-1	5, 6, 7, 8, 9
HB2179	DPA	6-0-0-0	10, 11, 12
HB2264	DPA	6-0-0-0	13, 14, 15
HB2503	DPA	6-0-0-0	16, 17, 18, 19
HB2504	DPA/SE	5-0-0-1	20, 21, 22
	COMMITTEE ATTENDANCE		23

Sandy Kelley

Sandy Kelley, Chairman Assistant
Tuesday, February 10, 2016

(Original attachments on file in the Office of the Chief Clerk; video archives available at http://www.azleg.gov)

Convened: 3:40 pm
Adjourned: 6:17 pm

REVISED #2 - 02/05/16 REVISED #2 - 02/05/16 REVISED #2 - 02/05/16

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

REGULAR MEETING AGENDA

COMMITTEE ON HEALTH

DATE Tuesday, February 9, 2016 ROOM HHR 4 TIME 2:00 P.M.

Members:

Mr. Boyer	Mr. Lawrence	Mrs. Cobb, Vice-Chairman
Mr. Friese	Mr. Meyer	Mrs. Carter, Chairman

Presentations:

Zika Virus Update

- Cara Christ, MD, MS, Director, Arizona Department of Health Services

PANDAS, PANS and Other Autoimmune Encephalopathies

- Susan E. Swedo, M.D., Pediatrics & Developmental Neuroscience Branch, NIMH, NIH Intramural Program, Bethesda MD

Voluntary Certification for Community Health Workers

- Floribella Redondo, President, Arizona Community Health Worker Association
- Susan Kunz, Director of Health and Wellness, Mariposa Community Health Center

Bills		Short Title	Strike Everything Title
HB2179	dpa	critical health information; emergency responders	
		(Gabaldón, Andrade, Bolding, et al)	
	6-0-0-0	TI dp 9-0-0-0-0, HEALTH, RULES	
HB2264	dpa	insurance; prescription eye drops; refills	
		(Brophy McGee: Carter)	
	6-0-0-0	HEALTH, RULES	
HB2309	dpa	children's health insurance program	
		(Cobb, Carter, Meyer, et al)	
	5-0-0-1	HEALTH, APPROP, RULES	
HB2503	dpa	psychologists; licensure compact	
		(Carter)	
	6-0-0-0	HEALTH held 0-0-0-0-0, RULES	
HB2504	dpa/SE	revenue department; technical correction	S/E: Physical Therapy Licensure Compact
		(Carter)	
	5-0-0-1	HEALTH, RULES	

ORDER OF BILLS TO BE SET BY THE CHAIRMAN

slk
2/5/16

People with disabilities may request reasonable accommodations such as interpreters, alternative formats, or assistance with physical accessibility. If you require accommodations, please contact the Chief Clerk's Office at (602) 926-3032, TDD (602) 926-3241.

Attachment 1

Information Registered on the Request to Speak System

House Health (2/9/2016)

HB2179, critical health information; emergency responders

Support:

Pat VanMaanen, representing self; Deb Gullett, Arizona Association Of Health Plans; Eddie Sissons, AZ Public Health Association; Barbara Burkholder, representing self; Tara Plese, AZ Alliance For Community Health Centers; Barbara Fanning, Arizona Hospital And Healthcare Association

HB2264, insurance; prescription eye drops; refills

Testified in support:

Trish Hart, AZ OPHTHALMOLOGICAL SOCIETY

Support:

Pele Fischer, AZ MEDICAL ASSN; Charles Schaffer, representing self

HB2309, children's health insurance program

Testified in support:

Dana Wolfe Naimark, CHILDREN'S ACTION ALLIANCE; Leonard Kirschner, representing self; Breann Westmore, MARCH OF DIMES BIRTH DEFECTS FOUNDATION; Rabbi Schneider, representing self; Elizabeth McKenna, representing self

Testified as neutral:

Kelly Whitener, representing self

Support:

Dianne Post, representing self; Joe Fu, CHILDREN'S ACTION ALLIANCE; Kelley Murphy, representing self; Joanna Marroquin, representing self; Eve Shapiro, representing self; Pat VanMaanen, representing self; Rory Hays, Arizona Nurses Association; Deb Gullett, Arizona Association Of Health Plans; Gini McGirr, League of Women Voters of Arizona, Legislative Chair, representing self; Brenda Thomas, ARIZONA FAMILY HEALTH PARTNERSHIP; Laura Dearing, The Arizona Academy Of Family Physicians; Erika Martinez, representing self; Jason Bezozo, Senior Program Director, Government Relations, BANNER HEALTH ARIZONA; Erin Hart, representing self; Susan Cannata, Arizona Chapter Of The American Academy Of Pediatrics, Maricopa Consumers Advocates And Providers, The Arc Of Arizona, The Arizona Academy Of Family Physicians; Denise Link, PhD, WHNP, representing self; Gina Griffiths, representing self; Erica Sussman, representing self; Paige Wambold, representing self; Eddie Sissons, AZ Public Health Association; Brandy Petrone, AZ Association Of Providers For People With Disabilities; Erin Raden, Arizona Child Care Association; Zaida Dedolph, PROTECTING ARIZONA'S FAMILY COALITION, Self; Ann Nichols, representing self; Sherry Griffin, representing self; Barbara Burkholder, representing self; Meghan Arrigo, representing self;

Elaine Wilder, representing self; Jennifer Carusetta, HEALTH SYSTEM ALLIANCE OF ARIZONA; Mary Busch, representing self; Pete Wertheim, Arizona Osteopathic Medical Association; Kirin Goff, representing self; Michelle Crow, representing self; Matt Jewett, representing self; Joshua Huggins, representing self; Nancy Jamison, representing self; Pele Fischer, AZ MEDICAL ASSN; Kristen Boilini, Arizona Alliance Of Community Health Centers; Ryan Harper, TENET HEALTHCARE CORPORATION; Sam Richard, PROTECTING ARIZONA'S FAMILY COALITION; Tara Plese, AZ Alliance For Community Health Centers; Susan Jacobs, representing self; Arthur Rogers, representing self; Andrea Chiasson, United Way of Tucson and Southern Arizona, representing self; kathyrn busby, HEALTH NET INC.; Brian Hummell, American Cancer Society Cancer Action Network; Timothy Schmaltz, Coordinator- PAFCO, representing self; Alexandria Kassman, representing self; Jeremy Arp, NATIONAL ASSOCIATION OF SOCIAL WORKERS, ARIZONA CHAPTER; Janice Palmer, AZ School Boards Assn; Kevin Earle, Executive Director, Arizona Dental Association; Emily Singleton, representing self; John MacDonald, Arizona Dental Association; Angie Rodgers, Association Of Arizona Food Banks; Bahney Dedolph, representing self; Surya-Patricia Lane Hood, representing self; Joan Serviss, Executive Director, AZ COALITION TO END HOMELESSNESS; ellen katz, William E. Morris Institute For Justice; Jim Dunn, Executive Director/CEO, NAMI Arizona, representing self; Carol Maas, representing self; Amanda Rusing, Arizona Bio Industry Association; Cynthia Zwick, Arizona Community Action Association; Diane E. Brown, AZ PUBLIC INTEREST RESEARCH GROUP (AZ PIRG); Bob Beauchamp, representing self; Alice Stambaugh, representing self; Leslie Croy, representing self; Kim VanPelt, representing self; Kathy Jorgensen, St. Vincent Depaul Society; Barbara Fanning, Arizona Hospital And Healthcare Association; Kellie MacDonald-Evoy, Arizona Coalition To End Sexual And Domestic Violence; Laura Jasso, representing self; Mikw Bielecki, Special Assistant to Governor Hull, representing self; Ron Johnson, AZ CATHOLIC CONFERENCE; Emily Jenkins, Arizona Council Of Human Service Providers; Jessica Michaels, representing self; Barbie Prinster, representing self; Steven Moortel, CHILDREN'S ACTION ALLIANCE; Ken Briggs, United Way of Tucson and Southern Arizona, representing self; Bethany Lambrecht, representing self; sara bode, representing self; Walt Gray, representing self; Donna Kruck, Ability360; Sonya Tenney, representing self; Eddie Sissons, Mental Health America Of AZ; Karla Birkholz, representing self; Jack Beveridge, representing self; Clifford Gross, representing self; jeff buel, Johnson & Johnson, Self; Norris Nordvold, INTER TRIBAL COUNCIL OF ARIZONA; Eric Schindler, representing self; Nicole Olmstead, American Heart Association; Jay Gittrich, representing self

Neutral:

Christopher Vinyard, AZ HEALTH CARE COST CONTAINMENT SYSTEM

Oppose:

Alexander Pope, representing self

All Comments:

Eve Shapiro, Self: Let's protect our children by providing access to heath care.; Gini McGirr, Self: Vote Yes on HB2309.; Dana Wolfe Naimark, CHILDREN'S ACTION ALLIANCE: Lifting the temporary freeze on KidsCare will help us move toward Gov Ducey's goal of opportunity for all at no cost to the state budget.; Brenda Thomas, ARIZONA FAMILY HEALTH PARTNERSHIP: The Arizona Family Health Partnership supports reinstating KidsCare in order to allow approximately 45,000 uninsured children access to health care. Reinstating KidsCare will have no impact on the state budget as it is 100% federally funded.; Eddie Sissons, AZ Public Health Association: Let's assure that our children have necessary health coverage. Please support this bill.; Kelly Whitener, Self: Kelly Whitener, Associate Professor Georgetown University Center for Children and Families; Ann Nichols, Self: Reinstating KidsCare enables health care coverage for many thousands of uninsured children. It brings back federal funding we have lost without burdening the state budget. Helps low income families whose parents work hard and need this program.; Sherry Griffin, Self: Please lift the enrollment freeze on Arizona's KidsCare. Funding for KidsCare comes from

federal tax dollars and will provide access to health care for thousands of Arizona's children.; Barbara Burkholder, Self: KidsCare is needed for children with chronic diseases like asthma, who need regular medical care in order to avoid hospitalization.; Elaine Wilder, Self: as a mother and social worker, it is imperative that every child become eligible for health care!; Mary Busch, Self: I am in favor of restoring the Children's Health Insurance Program. Children are Arizona's most important asset, and as such should be given the best opportunity to be healthy, no matter the economic status of their parents.; Matt Jewett, Self: Bringing back KidsCare is a no brainer! These are kids whose families make too much for AHCCCS but can't afford priv. insurance or don't have thru an employer. What's more, feds are paying 100% of the cost that'll go to other states if we don't use.; Leonard Kirschner, Self: KidsCare needs to be passed.; Nancy Jamison, Self: Please approve this bill to reinstate Kids Care for Arizona children. Let's use available federal dollars to provide health care to children who would otherwise go without or resort to emergency room care.; Alexander Pope, Self: We need to force parents to take care of thier own kids, not keep enabling to not step up.; Arthur Rogers, Self: Please support this bill which helps needy children.; Andrea Chiasson, United Way of Tucson and Southern Arizona, Self: Lift the freeze on KidsCare; Brian Hummell, American Cancer Society Cancer Action Network: The American Cancer Society Cancer Action Network strongly supports this legislation to restore health care options for vulnerable children in our state.; Alexandria Kassman, Self: Reinstating KidsCare is the right choice for Arizona. KidsCare could provide coverage to 40,000 young Arizonans with 100% matching federal funds,; Jeremy Arp, NATIONAL ASSOCIATION OF SOCIAL WORKERS, ARIZONA CHAPTER: Support Arizona families by removing the existing enrollment freeze on KidsCare, Arizona's CHIP program.; Kevin Earle, Arizona Dental Association: The Arizona Dental Association urges you to vote for restoring this valuable program for our children and families; Emily Singleton, Self: Please support HB2309. Research shows that uninsured children perform worse in school, are less likely to receive routine preventative care, and are at a higher risk for developmental delays than insured children.; Surya-Patricia Lane Hood, Self: Please vote for this Bill. It is much needed in Arizona.; Joan Serviss, AZ COALITION TO END HOMELESSNESS: Assuring access to healthcare, a livable wage and affordable housing are the three tenets to ending homelessness. Please secure passage of this legislation to assure healthcare coverage for the children of Arizona.; ellen katz, William E. Morris Institute For Justice: We need to lift the cap on this program and provide low-income children much needed quality health care. They are our future. The feds will reimburse at 100%.; Carol Maas, Self: We should take the opportunity to help our citizens with the tax money available through the Federal government. We paid it, let use it to do good by keeping children well, their parents at work and our state stronger with this investment.; Kim VanPelt, Self: St. Luke's Health Initiatives, an Arizona-based health foundation, strongly supports this bill. Lifting the freeze on KidsCare will help improve access to care for Arizona children.; Laura Jasso, Self: I am 70 yr and a member of f Arizona Grandparent Ambassadors. I am in full support. The Arizona legislature should step up and do what is right for all Arizona's children, no matter what economic states. All deserve basic quality of life.; Mikw Bielecki, Self: Mike Bielecki represents the Navajo Nation, whose children will benefit with the passage of H2309; Jessica Michaels, Self: PRO HEALTH CARE FOR KIDS; Bethany Lambrecht, Self: Valley Interfaith Project supports KidsCare. Healthcare is vital for our children. KidsCare serves children in families of the working poor, who are not eligible for AHCCCS, with no cost to the Arizona budget.; Elizabeth McKenna, Self: Representing the Arizona Chapter of the American Academy of Pediatrics; sara bode, Self: Dr. Bode speaking as a pediatrician with my experience with families whose children lack health insurance with the enrollment freeze of Kidscare; Walt Gray, Self: I join Ability 360 and other social service organizations in supporting HB2309 because healthy children reduce costs through preventive care and increase productivity in school, recreation & work.; Sonya Tenney, Self: I support Kidscare. Please restore this program. Our children need this support.; Clifford Gross, Self: As an Arizona Pediatrician who has had many patients and families hurt by lack of coverage, this is a no-brainer in terms of supporting this bill. It is embarrassing that Arizona is only US state without CHIP currently. Please pass this!!!; Norris Nordvold, INTER TRIBAL COUNCIL OF ARIZONA: Tribal Leaders support re-establishing Kids Care. More than 6,000 tribal children

were thrown off the rolls. This is at no cost to the state at this time; Eric Schindler, Self: Kids Care is crucial. All 49 other states have it

HB2503, psychologists; licensure compact

Testified in support:

Stuart Goodman, Arizona Board Of Psychologist Examiners

Support:

Garrick Taylor, Arizona Chamber Of Commerce And Industry; Tara Plese, AZ Alliance For Community Health Centers; Russell Smoldon, PHOENIX CHILDREN'S HOSPITAL; Annie Mooney, PHOENIX CHILDREN'S HOSPITAL; Barbara Fanning, Arizona Hospital And Healthcare Association; Robert Bohanske, representing self

HB2504, revenue department; technical correction

Testified in support:

Stuart Goodman, AZ STATE BOARD OF PHYSICAL THERAPY EXAMINERS; Cynthia Driskell, representing self

Testified as neutral:

Charles Brown, Executive Director, AZ Board Of Physical Therapy

Support:

Tara Plese, AZ Alliance For Community Health Centers; Amanda Rusing, Arizona Physical Therapy Association; Russell Smoldon, PHOENIX CHILDREN'S HOSPITAL; Annie Mooney, PHOENIX CHILDREN'S HOSPITAL; Tom Dorn, THE CORE INSTITUTE; shirley gunther, DIGNITY HEALTH; Jason Bezozo, Senior Program Director, Government Relations, BANNER HEALTH ARIZONA

All Comments:

Stuart Goodman, AZ STATE BOARD OF PHYSICAL THERAPY EXAMINERS: ...; Tom Dorn, THE CORE INSTITUTE: The Center for Orthopedic Research and Education supports the striker amendment.; Jason Bezozo, BANNER HEALTH ARIZONA: Support with the strike everything amendment; Cynthia Driskell, Self: Arizona Physical Therapy Association

PANDAS, PANS and Other Autoimmune Encephalopathies

Susan E. Swedo, M.D.
Pediatrics & Developmental Neuroscience Branch
NIMH, NIH Intramural Program
Bethesda MD

Nothing to declare or disclose.

PANDAS = Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections

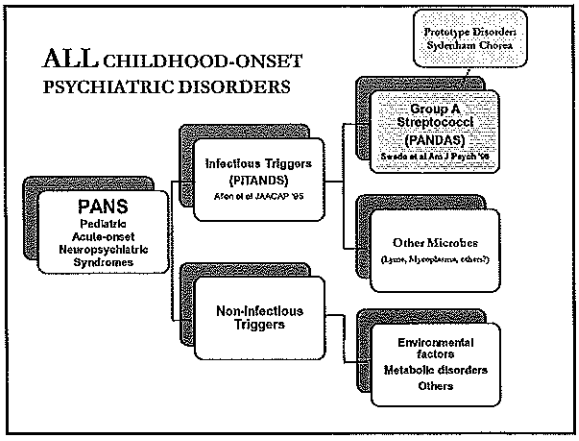
PANS = Pediatric Acute-onset Neuropsychiatric Syndrome

PANDAS/PANS Clinical Presentation

- ACUTE onset and episodic course of OCD &/or Eating disorder, and other symptoms

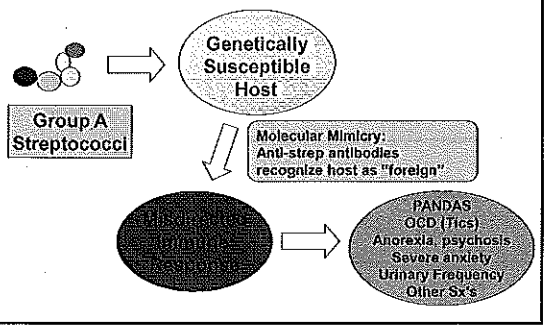
CASE EXAMPLE

* Obsessions
  - Insisting we go through doorways a particular way
  - Contamination fears
* Anorexia
  - Terrified of "being more than 50 lbs"
  - Distorted view of body
* Comorbid symptoms, including suicidal depression

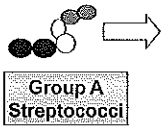


Attachment 3

Etiopathogenesis of PANDAS



Evidence that GAS is Etiologically Associated with PANDAS



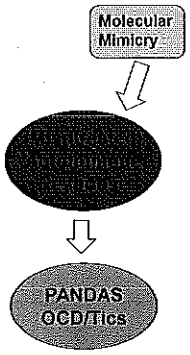
- Clinical observations and epidemiologic studies
- Treatment of GAS reduces OCD/tic exacerbations
- Prevention of OCD/tics with antibiotics prophylaxis
- Cross-reactive Antibodies Correlate with OCD/tics
- Animal models

Evidence that PANDAS Is "Autoimmune"

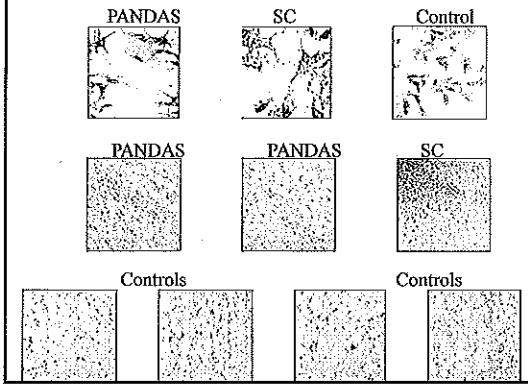
Local
Identification of antineuronal antibodies

Regional
Pathological reports from S. chorea
MRI - Volume changes in basal ganglia

Systemic
Serum Cytokine abnormalities
Effectiveness of immunomodulatory therapies (and their lack of effect for non-PANDAS OCD/tic disorders)



Kirvan & Cunningham: Cross-Reactive Antibodies



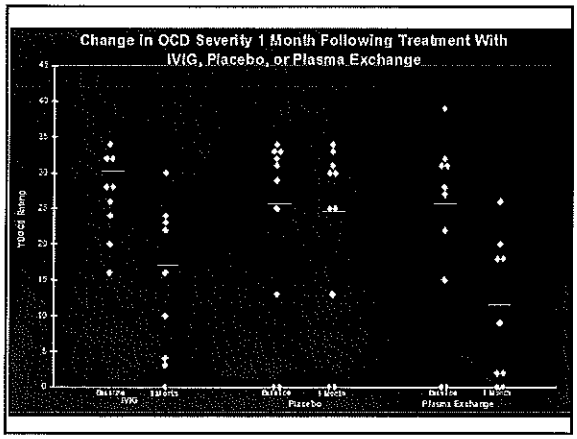
Transfer of Antibodies Produces Stereotypies and Behavior Changes

Production of symptoms by passive transfer fulfills the last of Witebsky's criteria for establishing a disorder as "autoimmune"

Immunomodulatory Treatment Trial Plasma Exchange vs. IVIG vs. Placebo

RANDOMIZATION

Plasma Exchange	IVIG	SHAM IVIG
N = 10	N = 9	N = 10



Response to Immunomodulatory Treatment

Baseline – unable to walk or perform ADL's without assistance

2 Weeks Post-plasmapheresis (No medications)

EARLY RECOGNITION IS KEY!

- Diagnosis is made on the basis of clinical history
- Prompt treatment is more effective and prevents suffering.
- Missed cases are at risk of permanent sequelae.

Outreach and education efforts will not only prevent suffering, but also save lives.

Attachment 4

Incorporating Community Health Workers into State Health Care Systems: Options for Policymakers

August 2015

BY KATE BLACKMAN AND SAMANTHA SCOTTI

Recent efforts to improve the effectiveness and efficiency of the public and private health care systems have increased state and federal policymakers' attention on community health workers (CHWs). Although the CHW profession is not new, health care payers and providers, including Medicaid, often partner with these workers. Their goal is to help people navigate a complex health care system, receive preventive care, manage chronic illnesses, maintain healthy lifestyles and assist people in receiving the care they need in culturally and linguistically relevant ways.

The American Public Health Association defines a community health worker as:

"...a frontline public health worker who is a trusted member of and has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."

STATE COMMUNITY HEALTH WORKER PROGRAM EXAMPLES

STATE	PROGRAM	KEY FUNDING	EXAMPLE OF CHW SERVICES
Idaho[i]	Idaho's Statewide Healthcare Innovation Plan uses CHWs for its patient-centered medical homes that deliver primary care, mainly in underserved areas.	Centers for Medicare and Medicaid Services, State Innovation Model Grant.	Provide health education and management to people in underserved areas with chronic conditions, e.g., diabetes management.
Kentucky[ii]	Kentucky Homeplace, established in 1994 and housed within the University of Kentucky Center for Excellence in Rural Health, employs CHWs in underserved and rural communities.	The Kentucky Department for Public Health contracts with the University of Kentucky Center for Rural Health. The legislature appropriates general funds for this program.[iii]	Help clients to access resources to meet their health care needs such as adequate food, eyeglasses and dentures.
Montana[iv]	Montana created a care coordination program that places CHWs within critical access hospitals to meet the diverse health care needs of a frontier state.	Frontier Community Health Care Coordination Demonstration Grant (HRSA-11-202).	Work to help elderly patients remain in their homes by evaluating their individual needs and connecting them to personalized care, e.g., physical therapy or other community resources.
Oregon[v]	Oregon's Patient Centered Primary Care Home Program covers services provided by certified CHWs. CHWs must be included on health care teams in the Coordinated Care Organizations (CCOs), which aim to provide the best quality health care at affordable costs.	Medicaid State Plan Amendment	Ensure patients regularly see their health care provider and receive chronic disease management, e.g., going to an asthma patient's house to ensure they are managing their condition properly.
South Carolina[vi]	The South Carolina Department of Health and Human Services' Health Access at the Right Time (HeART) initiative includes CHWs in primary care practices as community liaisons.	Eligible primary care physician practices receive a grant from the South Carolina Department of Health and Human Services. In addition, two billing codes are available for CHW services.	Encourage patients to follow appointment, medication and treatment schedules.

[i] State of Idaho, Idaho Statewide Healthcare Innovation Plan (Boise: Idaho, Dec. 20, 2013), http://healthandwelfare.idaho.gov/Portals/0/Medical/SHIP/IdahoSHIP.pdf.

[ii] University of Kentucky, Center for Excellence in Rural Health, About Kentucky Homeplace (Kentucky: University of Kentucky College of Medicine, 2015), https://ruralhealth.med.uky.edu/about-kentucky-homeplace.

[iii] National Academy for State Health Policy, State Community Health Worker Model (National Academy for State Health Policy, June 5, 2015), https://www.statereforum.org/state-community-health-worker-models.

[iv] Montana Rural Health Initiative, Rural Care Coordination Toolkit (North Dakota: Rural Assistance Center), http://montanaruralhealthinitiative.info/wp-content/uploads/2014/03/care-coordination-toolkit_RAC.pdf.

[v] Centers for Medicare and Medicaid Services, Re: Oregon State Plan Amendment (SPA): Transmittal Number 11-011, March 13, 2012 (Washington: Department of Health and Human Services, Centers of Medicare and Medicaid Services, 2007), http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/oregon-spa.pdf.

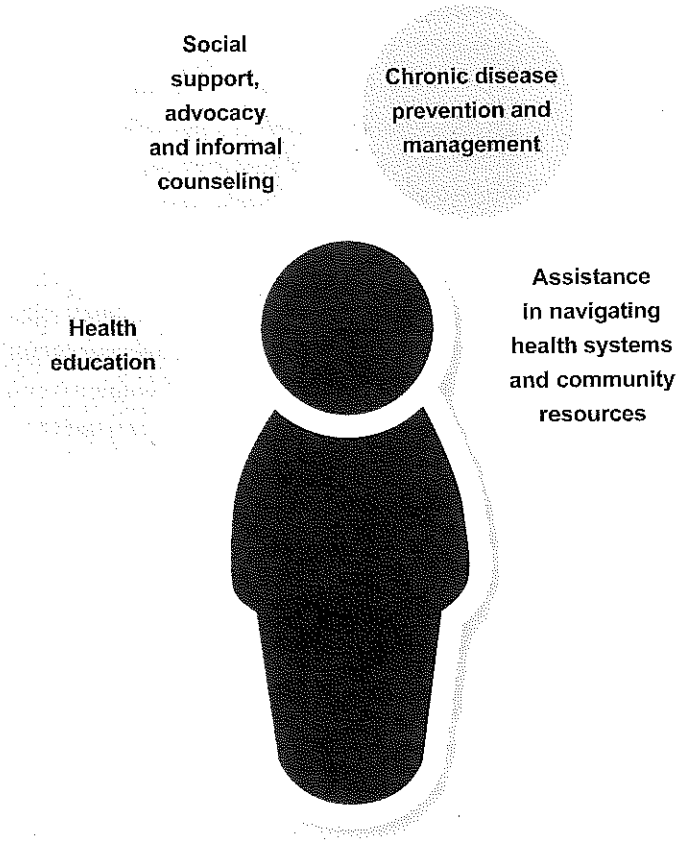
[vi] South Carolina Department of Health and Human Services, Role of a CHW (South Carolina: Health and Human Services), https://www.scdhhs.gov/sites/default/files/Community%20Health%20Worker%20FAQ.pdf.

Community health workers have a long history of service in the United States and are known by many titles, such as community health advisors, lay health advocates, outreach educators, community health representatives, promotoras (or peer health promoters), and peer health educators. They have been deployed in various settings—from primary care practices and hospitals to public health departments, community locations and patient homes—and their responsibilities can cover a wide area, including health education, chronic disease prevention and management, social support and informal counseling, and assistance in navigating health systems and community resources. These types of workers are also well positioned to reach patients in rural settings, who often encounter additional challenges accessing care. Additionally, many CHWs are volunteers, contributing to their community-based, grassroots nature.

The Bureau of Labor Statistics (BLS) estimates that as of May 2014, nearly 48,000 community health workers were employed across almost all 50 states.[1] It is important to note that the estimated size of the CHW workforce tends to vary, as the BLS and other groups define this workforce and its roles and responsibilities differently. For example, in 2007, the Health Resources and Services Administration reported roughly 86,000 CHWs assisting communities across the United States. This number is substantially higher as its definition of a community health worker is much broader and includes volunteers.[2]

The Affordable Care Act (ACA) and the Institute of Medicine, among others, have recognized the growing role community health workers play in health care. For example, the Department of Labor created an occupation code for CHWs in 2009, the ACA enabled grants to support using these workers in underserved communities, and the Centers for Medicare and Medicaid Services (CMS) altered a rule that makes it easier to pay for CHWs' services through Medicaid. In addition, many states included community health workers as part of the workforce plan in their Health Care Innovation grants, which were funded by CMS.

EXAMPLES OF COMMUNITY HEALTH WORKER RESPONSIBILITIES



CHWs' EFFECT ON QUALITY AND COST

Community health workers' role as "health brokers"[3] between communities and health care providers is widely considered to have the potential to improve quality of care while simultaneously controlling or decreasing costs. The workers' capacity to facilitate patients' self-management and access to appropriate clinical services could decrease costly and unnecessary hospitalizations, urgent care and emergency room visits, and improve quality of care. With these assumptions, CHWs have also been employed to work with "super-utilizer" patients—those who use more health services or frequently access high-cost services, such as emergency rooms.[4] In addition, community health workers are thought to strengthen providers' understanding of communities, which could improve care by building better cultural competence and communication between providers and patients.[5]

Despite acknowledgment of these potential benefits of community health workers, only a handful of programs across the country have studied their effectiveness. For example, an Arkansas CHW program saw a nearly three-to-one return on investment of Medicaid expenditures for a program that worked with Medicaid enrollees with unmet long-term care needs, and helped beneficiaries access appropriate home- and community-based services rather than costly nursing homes.[6] In Colorado, a Denver Health program employed CHWs to reach out to men in underserved communities to increase access to health care.[7] Denver's program found that it saved on the cost of health care services with a return on investment of more than $2 for every $1 spent on the program.[8] Some research also shows positive effects of CHWs on patients' health in some contexts and for certain diseases, such as hypertension or diabetes.[9]

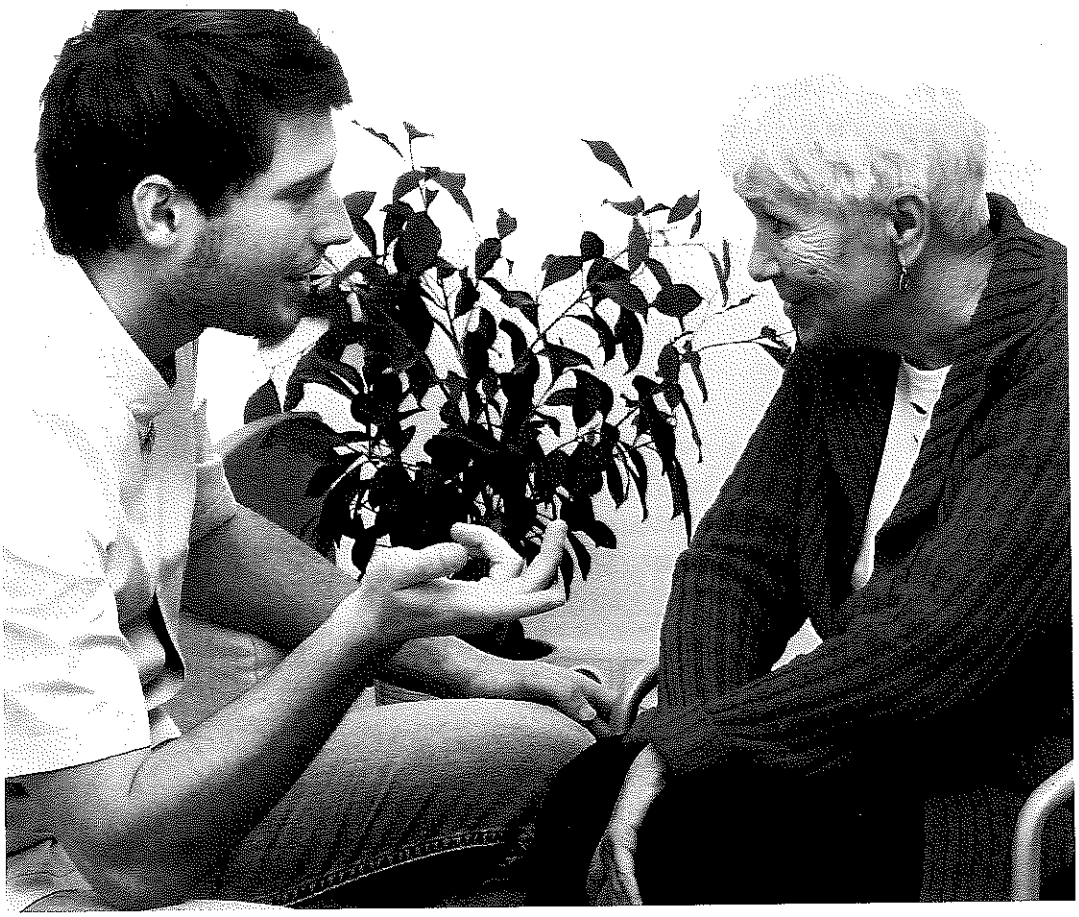
While there are a handful of published studies, the true effect of CHWs on patient care and health care costs is still difficult to determine, in large part due to limitations of the research.[10] For example, one review found some evidence that CHWs can positively influence patient behavior and health, but the evidence was insufficient to evaluate cost effectiveness.[11] In fact, very few studies have examined cost or cost effectiveness.[12] Preliminary cost effectiveness data are more frequently present within clinical service administrations that use community health workers, and these data often remain unpublished.[13] In addition, the variety of roles, settings and populations in which CHWs serve create challenges for rigorous evaluation.[14] And this diversity of contexts means that some findings may not be applicable in other health system settings.[15]

Overall, more research is needed to determine the effectiveness of community health workers. The Center for Medicare and Medicaid Innovation Models, which encourages the use of CHWs, requires its grant recipients to show cost savings and analysis of returns on investment.[16] As states implement pilots or programs using CHWs through this funding stream, they may generate more evidence upon which other states can build. And some states, such as Massachusetts, New Mexico and South Carolina, have included studies as part of funding or support for community health workers.[17]

CHWs AND HEALTH CARE TEAMS

The role of community health workers is well aligned with the goals of community care teams, primary care teams and medical homes around care coordination and access to care. CHWs' integration into primary care teams with doctors, nurses and other providers may help "magnify" the team's effects.[18] According to a review by the Centers for Disease Control and Prevention, evidence suggests that including CHWs in health care teams can extend the reach of CHWs and have a positive effect on patient health.[19] Integrating CHWs into multidisciplinary health care teams can be financed through mechanisms such as Medicaid, Medicare or private insurers.

In West Virginia, for example, CHWs are listed as possible members of the state's Health Home initiative care-provider teams, which are reimbursed by Medicaid through preset payments per member.[20] As team members, CHWs help provide services such as follow-up care after patient discharge to avoid the need for additional medical services.[21] CHWs are similarly integrated into Vermont's Community Health Teams, whose services are paid for by Medicaid, Medicare and the state's major insurers. Vermont's Blueprint for Health, a statewide public-private partnership focused on improving health care, uses CHWs to provide a variety of services, such as attending medical appointments with patients and assisting with transportation or child care.[22]



CHWs AND MEDICAID

Community health workers can be deployed to reach Medicaid beneficiaries, especially as state programs increasingly move toward a comprehensive approach that addresses patients' barriers and needs, and emphasizes preventive and coordinated care.[23]

The Centers for Medicare and Medicaid Services changed a rule, as of 2014, that expanded reimbursement of preventive services and helped facilitate reimbursement for CHW services through state Medicaid programs.[24] State Medicaid programs are now allowed to reimburse community-based preventive services recommended by a physician or other licensed provider, and the services can be delivered by practitioners other than a physician—such as CHWs. States wishing to incorporate the flexibility under this rule must create a state plan amendment and define both CHWs and the services they provide.[25]

Prior to the rule change, a few states funded CHWs under Medicaid through different mechanisms. Minnesota passed legislation in 2007 to become one of the first states to reimburse for

FINANCING COMMUNITY HEALTH WORKERS

Funding is one of the challenges to creating and maintaining CHW efforts in many states. CHWs are funded through a variety of federal, state, local and private dollars, including:

- Federal, state and private grants
- State and local health departments
- Medicaid
- Hospitals and clinics
- Private insurers
- Community-based organizations
- University and college research projects

Some funding is for temporary projects. In addition, a number of CHWs are volunteers. See "Sustainable Financing" section on page 7 for more information.

CHW services under Medicaid. The legislation stipulated requirements for certification or experience, supervision and services covered.[26] State Medicaid programs that include managed care or capitated (e.g., per-patient, per-month) rates—versus fee-for-service reimbursement—have traditionally had flexibility to fund CHWs through care teams.[27] For example, New Mexico used a Medicaid demonstration waiver and required its managed care organizations to make CHWs available as a resource for beneficiaries and care coordination staff.[28] In addition, Michigan received approximately $70 million under a State Innovation Model grant from the Center for Medicare and Medicaid Innovation for its Blueprint for Health model. This model creates Accountable Systems of Care (ASC), which encourage greater incorporation of CHWs into health care teams in areas such as prenatal care and birth outcomes.[29]

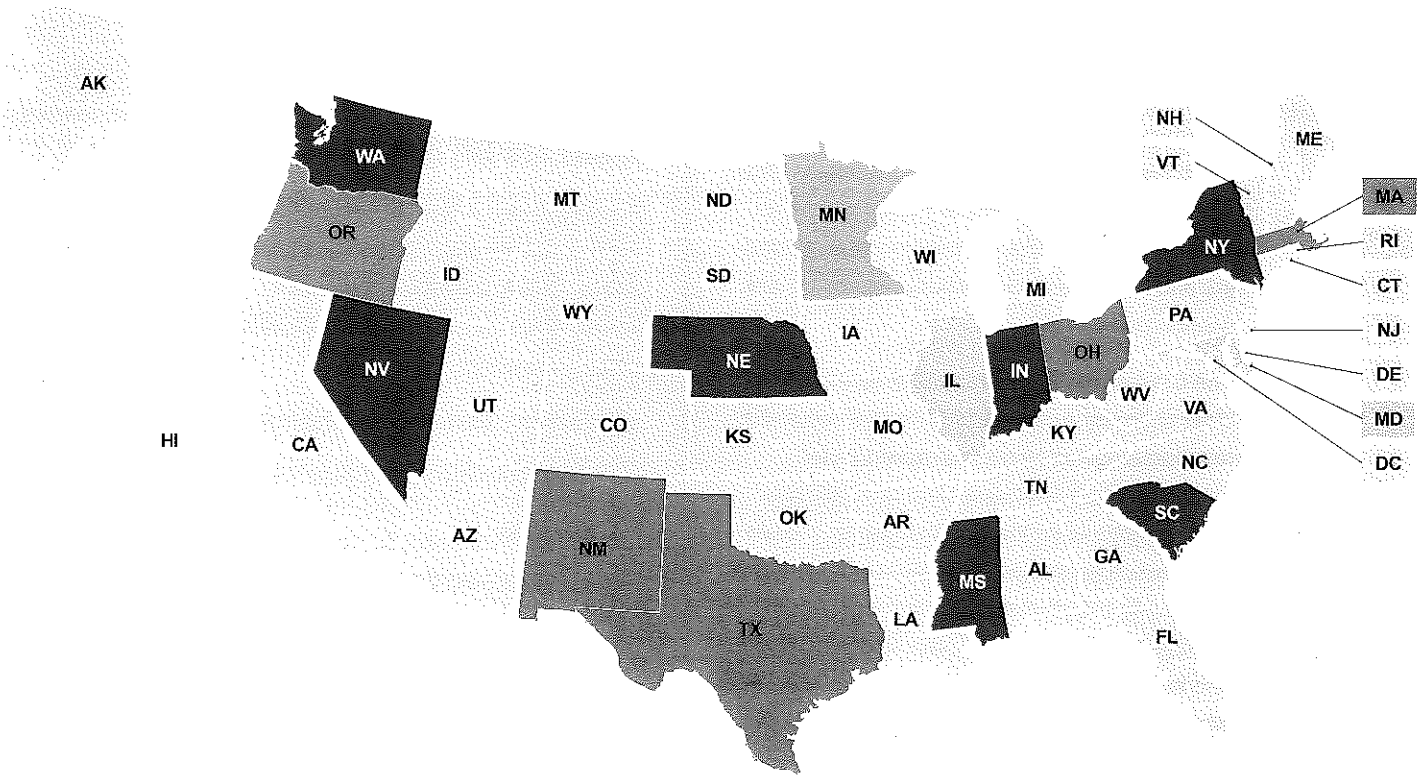
STATE LEGISLATIVE ACTION AND POLICY CONSIDERATIONS

As lawmakers examine CHW programs, prior evidence, demonstrations and legislation suggest a few key areas on which policy consideration and action could be focused.

Occupational Regulation

Occupational regulation, which involves certification, licensing or other credentials for community health workers, falls under the purview of state legislatures. States may consider occupational

COMMUNITY HEALTH WORKER TRAINING/CERTIFICATIONS



Source: Association of State and Territorial Health Officials, Updated March 2015

regulation to create standards for the CHW profession, which has typically been very broadly defined. Credentialing requirements can include required training, skills, competencies and a standard scope of practice, which would delineate CHWs' practice abilities and limitations. Credentialing can also serve as the basis to enable reimbursement or payment for CHW services. At least five states—Massachusetts, New Mexico, Ohio, Oregon and Texas—currently have laws or regulations establishing CHW certification program requirements, and Illinois, Rhode Island and Maryland passed laws that require a work group or task force charged with determining requirements.[30] Other states have established processes or are working towards establishing certification processes through state agencies or other non-legislative directives. However, some CHW organizations worry that enacting uniform occupational regulations or requirements will be too restrictive for a field that has traditionally been community-driven with few barriers to entry, and may prohibit some from entering the profession.[31]

Policymakers considering occupational regulation of CHWs may explore:

- Determining if the state has existing standards for non-clinicians providing preventive care, and, if not, consider establishing qualifications.[32]
- Creating a credentialing commission, task force or other work group to examine the most applicable state-specific standards.
- Developing certification programs or requirements that are based on a set of core competencies needed for CHWs across the state[33] and consider specialized certification standards for CHWs in specific programs.
- Defining a scope of practice for CHWs that allows the workers and other team members to provide care at the top of their skill set.[34]
- Recognizing the CHW standard occupational classification, set by the Department of Labor in 2009.[35]

Workforce Development

Similar to credentialing, decision-makers are considering the education, training and other needs to adequately develop the CHW workforce to meet

the needs of their states. Training for CHWs varies widely; it can be through formal educational institutions or learned on the job.[36] Standards commonly focus on skills and competencies rather than achieving specific education levels. At least six states—Indiana, Nebraska, Nevada, New York, South Carolina and Washington—have training programs, some of which are connected to certifications and were established by state agencies.[37] Lawmakers investigating CHW workforce issues may:

- Set state-level standards for education or training that focus on needed skills and competencies.[38]
- Encourage the development of training programs in the health department, other state agencies or other entities.
- Develop or require specific training (e.g., disease-specific training) necessary for certain jobs.[39]
- Allow training to be provided by clinicians, experienced CHWs or supervisors in CHW programs.[40]
- Consider training for CHWs and other health care providers that helps CHWs integrate into care teams.[41]

- Allocate resources for CHW workforce development, including training.[42]

Sustainable Financing

Historically, community health workers have been financed through a "patchwork of funding" with time-limited grants and numerous volunteer CHWs.[43] Through mechanisms including the 2014 Medicaid rule (described earlier), Medicaid demonstration projects, Medicaid managed care and the federal State Innovation Model (SIM) initiative, states are exploring sustainable financing models to develop and expand the use of CHWs by:

- Creating state policies that pave the way for direct CHW reimbursement, such as defining CHW services and eligibility to provide services.
- Encouraging state Medicaid programs to explore payment options, including managed care contracts, to support CHWs[44] or other mechanisms under the recently changed Medicaid rule.
- Considering a demonstration waiver or state plan amendment to reimburse for CHW services through Medicaid.[45]
- Applying for a federal State Innovation Model grant to test and evaluate a new model that incorporates CHWs in an effort to reduce costs and improve quality in Medicaid and Medicare.
- Working with managed care organizations and private payers to develop reimbursement models for CHWs.[46]
- Examining the option to add CHWs to care teams, especially for those states considering reforms to health care payment and delivery systems that support integrated or patient-centered care. [47]
- Considering reimbursement levels at wages that help maintain CHWs in the workforce.[48]
- Supporting data collection or research on the cost-effectiveness of CHWs.

CONCLUSION

In efforts to reform health care delivery and payment systems — with the goal to improve quality and lower costs — many states are looking to leverage lower-cost resources such as community health workers. State decision-makers have multiple policy options to consider related to occupational regulation, workforce development and funding of CHWs. Policymakers can also support data collection and analysis to help further the research to better understand the roles and opportunities related to CHWs, and continue to inform innovative, cost-effective state health policy.

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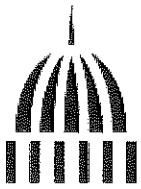

NATIONAL CONFERENCE of STATE LEGISLATURES

William T. Pound, Executive Director

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State of Arizona
House of Representatives
Health Committee
Informational Meeting

Community Health Worker Voluntary Certification

1. Community Health Worker Workforce in Arizona
2. Community Health Worker Roles in a Coordinated Care Model
3. Community Health Worker Return on Investment
4. Community Health Worker Voluntary Certification Guidelines
5. Supporting Organizations
6. National Conference of State Legislators: Incorporating Community Health Workers into State Health Care Systems: Options for Policymakers

Prepared by:

The Arizona Community Health Worker Association
The Arizona Community Health Worker Workforce Coalition

Presented by:

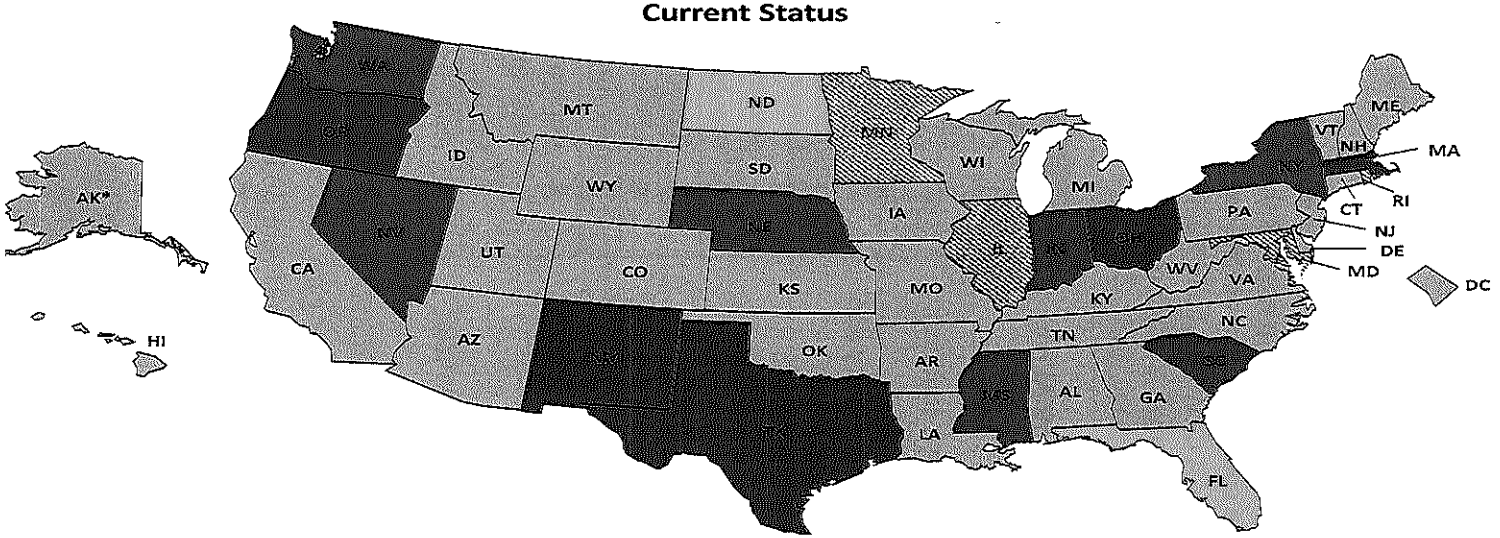
Floribella Redondo, Arizona Community Health Worker Association
Lisa Blue, Adelante Community Health Centers

Trends in CHW Certification

astho™

Community Health Workers (CHWs) Training/Certification Standards

Current Status



- Laws/Regulations Establish CHW Certification Program Requirements
- Statute Creates a CHW Advisory Board, Taskforce, or Workgroup to Establish Program Requirements
- No Law; But Has State-led Training/Certification Program
- Medicaid Payment for Certified CHW Services
- Pending Legislation
- None

* AK does not have a state-run CHW training program, but statutorily provides community health aide grants for third-parties to train community health aides.

Last updated: 3/16/2015

Community Health Worker Workforce

Over 1000 CHWS are employed in community organizations, community health centers and health systems throughout Arizona

CHWs serve all 15 Arizona counties and 19 Tribes

AzCHOW
Arizona Community Health Workers Association

CHW WORKFORCE DEFINITION

A frontline public health worker who is a trusted member of and/or has an in depth understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. *American Public Health Association*

CHWs ARE DISTINCT FROM OTHER HEALTH PROFESSIONS:

- ✓ Relationship and trust-building – to identify specific needs of clients
- ✓ Communication – especially continuity and clarity, between provider and patient
- ✓ Focus on social determinants of health – conditions in which people are born, grow, work, live, and age

CHW 10 Core Roles
1. **Cultural mediation among individuals, communities, and health and social service systems**
2. **Providing culturally appropriate health education and information**
3. **Care coordination, case management, and system navigation**
4. **Providing coaching and social support**
5. **Advocating for individuals and communities**
6. **Building individual and community capacity**
7. **Providing direct service**
8. **Implementing individual and community assessments**
9. **Conducting outreach**
10. **Participating in evaluation and research**

CHW IMPACT HEALTH OUTCOMES:

A 2015 **survey of 364 licensed Arizona health providers** found:

- ✓ **90%** say CHWs have had a positive impact on patient care.
- ✓ **No less than 70%** reported that as a result of working with CHWs their patients were more likely to follow their recommendations, maintain regular care, better mange their chronic disease and have access to care
- ✓ **70%** agree CHWs have contributed to the prevention of high risk or high cost health conditions
- ✓ **75%** would be more likely to utilize CHWs as part of the health care team if CHWs service were reimbursable by AHCCCS or third-party payers.

Arizona Community Health Workers Association and the Arizona Community Health Worker Workforce Coalition consisting of more than 60 organizations throughout the state supports:

Voluntary certification to standardize the competencies and scope of practice and establish professional recognition and career development for CHWs. A standardized CHW workforce will benefit the health care system by ensuring the positive health outcomes associated with CHW services.

CHW Cost-Effectiveness

Demonstrated cost-effectiveness across multiple target groups with varying needs

Program	Arkansas Community Connector Program†	Molina Healthcare New Mexico‡	Arizona Health Start⁻
Population	Medicaid at risk for institutional long-term care	Medicaid high utilizers	High-risk pregnancies
Intervention	Connection to home & community-based long-term care	Coordination with providers for preventive care	Facilitate prenatal and postpartum care (2 yrs for child)
Outcome	Prevented 24% of three year costs	Reduction in ED, inpatient, total cost	Health Start 12% more likely to have normal weight baby
ROI	$2.92	$4.37	$3.37

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Community Health Worker Roles
Within a Coordinated Care Model
Examples from Arizona

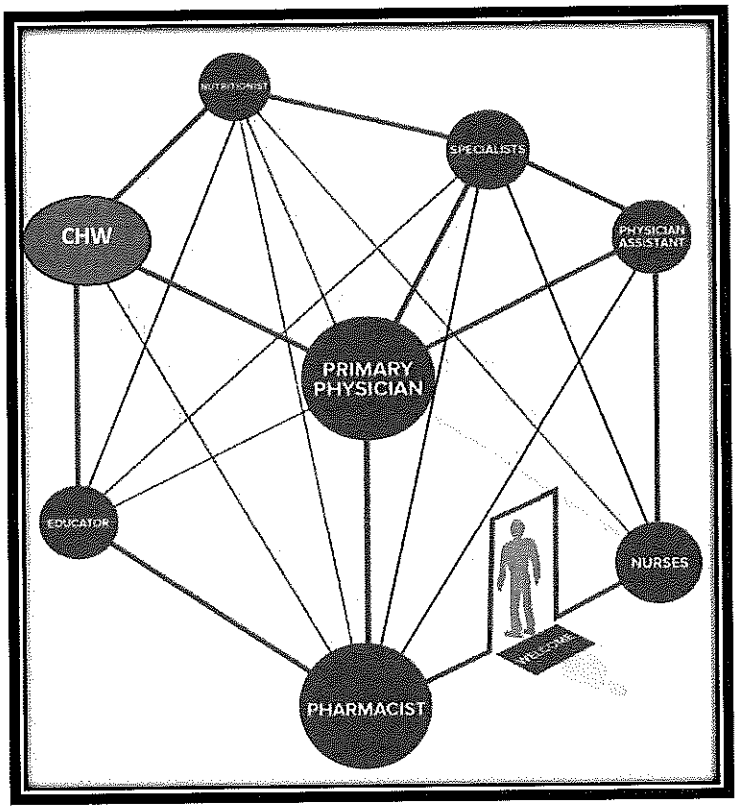
Patient Health Outcomes

- **20% reduction in hospital admissions.**
- **30% of high risk patients with diabetes (>8.0 HbA1c) under control.**
- **Average 1% reduction in HbA1c among high risk patients with diabetes.**
- **Average 20 point decrease cholesterol among high risk patients.**
- **Decrease in appointment no-shows.**
- **Increased patient engagement with provider recommendations in primary & specialty care.**

Adelante Healthcare
Phoenix, AZ

Health Coach

- patient education/counseling
- Glucometer/insulin teaching
- Assisting patient with identifying available community resources
- Transition of care calls-scheduling follow up, medication reconciliation
- Transfer to RN if patient has medication questions
- Health plan data; care opportunities Pre-visit planning-screening/preventive care



Banner University Medical Group
Tucson

Community Health Partners

- Home-based, interdisciplinary care management model
- Funded by University of Arizona Health Plans
- Focus on high utilizers of hospital services
- Chronic disease self-management support
- Transitions of care support
- Primary care visit preparation and accompany to visits
- Medication adherence support
- Community resource navigation
- Behavioral health care coordination

Mariposa Community Health Center
Nogales, AZ

Care Coordinators

- Home visiting
- Chronic disease self-management education and support
- Glucometer support
- Follow up with patients from hospital or emergency room visits
- Health promotion education
- Referral and follow up

AzCHOW
Arizona Community Health Workers Association

Proposed Voluntary Certification Process for Community Health Workers

What CHWs need to know to become certified in Arizona

The Arizona Community Health Workers (AzCHOW) Training Center works closely with key stakeholders, community-based and health care organizations throughout the state to ensure Community Health Workers (CHWs) are recognized and certified as a strong professional workforce in Arizona. Although CHWs go by many titles (*promotora,* peer health specialist, patient navigator, and community health representative), Community Health Worker (CHW) is the official title recognized by the U.S. Bureau of Labor. To ensure the integrity of the CHW workforce, AzCHOW has developed a voluntary certification path for CHWs in Arizona.

Why Get Certified?

●Certification documents that a person has received training in the required core competencies of the workforce ● Certification prepares the CHW workforce to be knowledgeable and ethical ● Certification promotes the recognition of the value that CHWs bring to the health care system ● Certification can increase the potential for employment opportunities●

Who Can Get Certified?

Community Health Workers who work or volunteer in community service organizations and or health systems such as: community health centers, community-based organizations, hospitals, schools, churches and community centers are eligible for certification.

Voluntary CHW Certification Requirements

Voluntary CHW Certification Requirements
18 years or older and have a physical address in Arizona*
Documentation of 2500 hours of paid or volunteer CHW experience in the past two years OR Completion of an AzCHOW approved CHW training curriculum and 1000 hours of paid or volunteer CHW experience.
Completion of AzCHOW training center CHW Core Competency Training/Assessment (4 hours)
Two professional letters of recommendation
$100.00 certification fee (includes 4-hour CHW Core Competency Training/Assessment)
Voluntary Certification requires renewal every 2 years ($50 fee for renewal). Eight hours of ongoing training per year must be documented for renewal.

*All applicants must have a personal email address

For more information on the certification process or on AzCHOW certified training programs, visit: www.azchow.org
Or Contact: *Floribella Redondo, President, AzCHOW Association (928) 366-3016 floribella@azchow.org*

AzCHOWs Training Center Mission:
Represent, capacitate and develop a strong professional CHW workforce in Arizona

ORGANIZATIONS IN SUPPORT FOR VOLUNTARY CERTIFICATION OF COMMUNITY HEALTH WORKERS IN ARIZONA

Alzheimer's Association Desert Southwest Chapter

Arizona Advisory Council on Indian Health Care

Arizona Alliance for Community Health Center

Arizona Community Health Worker Outreach Network

Arizona Prevention Research Center

Arizona Western College

Campesinos Sin Fronteras

Center for Rural Health

Central Arizona College

Coconino County Public Health Services District

Empowerment Systems, Inc.- Greater Valley AHEC, Arizona Living Well Institute

Esperanca

Family Spirit

Hualapai Health Education & Wellness Community Health Representative Program

Havasupai Tribe

HonorHealth

Kaibab Paiute Tribe
Maricopa County Department of Public Health

Maricopa County Department of Public Health, Office of Family Health, Healthy Start Program

Maricopa County Department of Public Health, Office of Tobacco and Chronic Disease Prevention

Mariposa Community Health Center

Multicultural Initiatives, American Heart Association

Native Americans for Community Action, Inc.

Native Health

National Consultant for the CHW Core Consensus (C3) Project

NAZCARE

North Country HealthCare

Pima Community Access Program

Pima Community College

Regional Center for Border Health, Inc. and the San Luis Walk-In Clinic, Inc. (Rural Health Clinic)

Southeast Arizona Area Health Education Center

Southwest Behavioral and Health Services and Padres Promotores from the South Mountain WORKS Coalition

St. Luke's Health Initiatives
Sunset Community Health Center

Tribal & Northern Coordinator, Office of Community Health Workers, NM Dept. of Health

Unlimited Potential

Valle del Sol

WellWays Program

WMAT Division of Health Programs

HOUSE OF REPRESENTATIVES

HB 2309

children's health insurance program
Prime Sponsor: Representative Cobb, et al., LD 5

X Committee on Health

Committee on Appropriations

Caucus and COW

House Engrossed

OVERVIEW

HB 2309 eliminates the enrollment cap on the Children's Health Insurance Program (CHIP) administered by the Arizona Health Care Cost Containment System (AHCCCS).

PROVISIONS

1. Eliminates the enrollment cap on CHIP and makes necessary conforming changes.
2. Repeals A.R.S. § 36-2985 (Enrollment cap; program termination; spending limit)
3. Requires AHCCCS, within five days after the effective date, to do both of the following:
   a. Submit to the Centers of Medicare and Medicaid Services (CMS) a state plan amendment to resume enrollment in CHIP; and
   b. Project the enrollment rate for CHIP for the remainder of federal fiscal years 2016 and 2017 and request from CMS any additional allotment needed to resume enrollment in CHIP.
4. Contains a conditional enactment of sections A.R.S. §§36-2982 and 36-2986, respectively (children's health insurance program and administration non-entitlement; enrollment; eligibility) and (administration; powers and duties) as amended by this act do not become effective unless on or before July 1, 2017 CMS approves this state's plan amendment to resume enrollment in CHIP.
5. Contains a conditional enactment of the repeal of A.R.S. § 36-2985 (enrollment cap; program termination; spending limitation) do not become effective unless on or before July 1, 2017, CMS approve the state plan amendment to resume enrollment in CHIP.
6. Requires the director of AHCCCS to notify in writing the Director of Arizona Legislative Council on or before July 15, 2017 either:
   a. Of the date on which the condition was met; or
   b. That the condition was not met.
7. Makes technical and conforming changes.

CURRENT LAW

A.R.S. Title 36, Chapter 29, Article 4 are the statutes related to CHIP.

ADDITIONAL INFORMATION

The CHIP program provides health coverage to children in families with incomes between 133% and 200% of the federal poverty level, but above the levels required for the regular AHCCCS

program. Beginning on October 1, 2015 CHIP will receive a 100% federal match rate through September 20, 2019. The CHIP program has had an enrollment freeze since January 1, 2010. The CHIP program will receive a 3:1 federal match rate for the first quarter of state fiscal year (FY) 2016 and a 100% federal match rate beginning on October 1, 2015 thereafter a weighted blended FY 2016 rate of 94.48% FY 2016 Appropriations Report (see page 39).

Fifty-second Legislature
Second Regular Session

Health
H.B. 2309

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2309

(Reference to printed bill)

Page 2, strike lines 16 through 42

Strike pages 3 and 4

Page 5, strike lines 1 through 29, insert:

"Sec. 2. Section 36-2985, Arizona Revised Statutes, is amended to read:

36-2985. Notice of program termination; spending limitation

A. If the director determines that monies may be insufficient for the program, the director shall immediately notify the governor, the president of the senate and the speaker of the house of representatives. After consulting with the governor, the administration shall stop processing new applications for the program until the administration is able to verify that funding is sufficient to begin processing applications and the governor agrees that the administration may begin processing applications.

B. If the federal government eliminates federal funding for the program ~~or significantly reduces the federal funding below the estimated federal expenditures~~ AS SPECIFIED IN 42 UNITED STATES CODE SECTION 1397ee, the administration shall immediately stop processing all applications and shall provide at least thirty days' advance notice to contractors and members that the program will terminate.

C. The total amount of state monies that may be spent in any fiscal year by the administration for health care provided under this article shall not exceed the amount appropriated or authorized by section 35-173.

Attachment 6

Adopted ✓ # of Verbals ____
Failed ____ Withdrawn ____
Not Offered ____ Analysts Initials ____

D. This article does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or ~~to~~ create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose."

Renumber to conform

Page 6, line 2, strike "36-2986" insert "36-2985"

Lines 3 and 4, strike "and the repeal of section 36-2985, Arizona Revised Statutes, by this act" insert a comma

Amend title to conform

REGINA COBB

2309COBB
02/05/2016
11:43 AM
C: MJH

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2309

DATE February 9, 2016 MOTION: d pa

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer					✓
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		5	0	0	1

Sandy Kelly
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 7

THE AMERICAN ACADEMY OF
PEDIATRICS
ARIZONA CHAPTER

2600 N. Central Ave., Suite 1860
Phoenix, AZ 85004
602.532.0137 office
602.532.0139 fax
www.AzAAP.org
TAX ID 86-0917603

Madame Chairwoman Carter, Members of the Committee,

My name is Dr. Elizabeth McKenna. I am a pediatrician in the East Valley and am speaking on behalf of the over 900 pediatricians and pediatric healthcare providers who are members of the Arizona Chapter of the American Academy of Pediatrics.

I am a pediatrician and co-owner of Healing Hearts Pediatrics. We have twelve providers and three offices in Chandler, Gilbert and Queen Creek. We take care of over 15,000 patients and their families.

Every day we have patients who do not have health insurance. Many make too much for AHCCCS but too little for private insurance or ACA Marketplace plans. Many have a parent who receives health insurance from an employer, but their family and children don't, and are ineligible for subsidies to help pay for health insurance.

When the temporary KidsCare II ended in 2014, many children from the working poor, lost their healthcare coverage. These are children from hard working families who do not qualify for AHCCCS but cannot afford private insurance premiums. It was thought that many would be eligible for Marketplace plans, but it rapidly became clear that the deductibles and copays required on these plans were prohibitively expensive for many working families, trying to take care of their children.

To illustrate, we take care of a family with five children. The father works as a grocer, but makes $20 too much for AHCCCS. One of their children has significant developmental delay, and another has a serious neurological disease called neurofibromatosis. After the youngest child was born, it became clear that he most likely had neurofibromatosis as well. We referred the youngest child for evaluation for neurofibromatosis, but the family was unable to bring him in to the neurologist, because they could not afford the office visits and diagnostic testing necessary to make the diagnosis and create a treatment plan. Hence the child had delayed treatment and provision of needed services. Their child with developmental delay also had delayed diagnosis and provision of appropriate therapy, because they could not bring him in for his regularly scheduled well visits. This family could have been helped if KidsCare had been in existence, because they were in the range of family incomes which was covered by KidsCare.

When children are uninsured their families are unable to bring them in when they are sick, so a minor illness like a cold or bronchitis, which could have been taken care of by their primary care doctor, can turn into a major illness, like pneumonia, requiring Emergency Room care, and often times admission to the hospital. This, oftentimes uncompensated acute care, can be very costly to the hospitals and the state. Sick children, who do not receive treatment, because they do not have health insurance, have prolonged and persistent illness, and miss school and necessary learning, and their parents miss work.

Attachment 8

THE AMERICAN ACADEMY OF
PEDIATRICS
ARIZONA CHAPTER

2600 N. Central Ave., Suite 1860
Phoenix, AZ 85004
602.532.0137 office
602.532.0139 fax
www.AzAAP.org
TAX ID 86-0917603

Children without health insurance, also are likely to miss preventive healthcare visits, and miss required vaccinations to prevent serious transmittable diseases as well as important screenings for vision, hearing, and development. They are at greater risk for developmental delays.

KidsCare will be 100% paid for by the US Department of Health and Human Services. There will be no cost to the state budget. Arizona is the only state in the country without functioning CHIP coverage. Arizona needs KidsCare to help its children, who are its future, succeed in life, and become contributing members to society.

We ask you to please lift the temporary freeze on KidsCare. It is not a republican issue or democratic, or a political matter. It is just right to take care of your children. Thank you for the opportunity to speak on behalf of this bill and I would be happy to answer any questions.

Elizabeth G Homans McKenna, MD
Member, Board of Directors, AzAAP
Healing Hearts Pediatrics, PLC
emckenna@healingheartspeds.com

FACT SHEET

Cover Kids COALITION

Lifting the Temporary Freeze on KidsCare

Background

KidsCare is Arizona's State Children's Health Insurance Program (CHIP). Before it was temporarily frozen, KidsCare provided high quality, affordable, and cost-effective health care to low income children from working families. KidsCare covers children in families with incomes from 138 percent to 200 percent of the federal poverty level, or $27,000-$40,000 for a family of three.

Arizona has had a temporary enrollment freeze on KidsCare for the past five years and is the only state in the country without functioning CHIP coverage.

KidsCare Is Good for the Economy and Arizona's Budget

Beginning October 1, 2015, KidsCare in Arizona will be 100 percent paid for by the U.S. Department of Health and Human Services. There will be no cost to the state budget. State laws for the KidsCare program are still in place. Lifting the temporary freeze on KidsCare requires approval by Governor Ducey and the legislature to allow AHCCCS to spend federal funds and to re-open enrollment. Between 30,000-40,000 children in Arizona are expected to enroll.

100% of the costs of KidsCare is paid for by CHIP—with *no cost* to the state budget

KidsCare Has a Proven Track Record of Success with Bipartisan Support

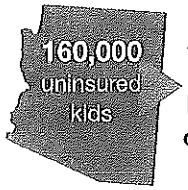
1. **KidsCare is a public private partnership.**
   Health insurance companies contract with AHCCCS to offer kids robust health plans with benefits and provider networks designed with children in mind.
2. **Families share the cost.**
   KidsCare families have a vested interest in their children's health care because they are required to pay monthly premiums.
3. **KidsCare has improved the health of thousands of Arizona kids.**
   At its peak, KidsCare helped over 63,000 children get access to health care. When KidsCare was available, Arizona saw notable improvements in children's health coverage.

Attachment 9

Why Arizona Families Need KidsCare

Arizona has too many kids without access to health care.

Arizona has the third highest percentage of uninsured children in the US—around 160,000 kids.



Arizona has the third highest rate of uninsured children in the U.S.

Children need health insurance to grow up healthy, learn, and thrive.

A large body of evidence shows that uninsured children perform worse in school than insured children, are less likely to receive preventive health care such as vaccinations and screenings, get sick more often, and are at greater risk for developmental delays.

KidsCare works better for many children than the "Obamacare" Marketplace.

KidsCare health plans are designed with children in mind, which provides children better access to doctors and health care benefits. Even with subsidies, Marketplace plans are financially out of reach for children who would qualify for KidsCare. Costs for co-payments and deductibles in Marketplace plans may prevent children from getting the health care and medicines they need. All KidsCare plans are closely monitored to make sure children are on track with their well child visits, routine checkups, and screenings.

KidsCare is very important for kids with complex health needs.

High costs to families in Marketplace plans hurt kids with special health care needs the most. In a study by Georgetown University, researchers found that children with special health care needs face substantially higher costs and exhaust certain benefits that are essential to their health. For a child with cerebral palsy, for example, health costs could exceed 15 percent of the family's income. Children with common health care needs can see health care costs to families that are 2 to 8 times higher than the costs of KidsCare.

KidsCare protects Arizona children from flaws in the Affordable Care Act.

Over half of low income children who could qualify for KidsCare might be locked out of tax credits or subsidies due to a feature of the Affordable Care Act known as the family glitch. This feature means that children won't qualify for financial assistance if one parent has access to affordable coverage through their employer—even if the cost of family coverage would be out of reach. Without KidsCare, thousands of families in Arizona are priced out of health coverage.

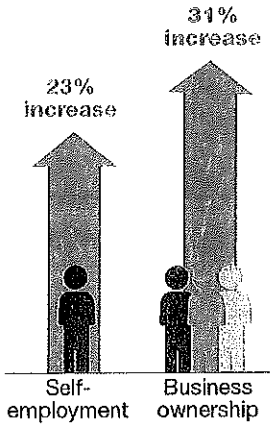
KidsCare prevents the need for foster care and helps foster children transitioning home.

KidsCare provides families access to important behavioral health services that keep children safe and families together.

KidsCare Is Good for Business

CHIP stimulates entrepreneurship and helps families start small businesses.

Research from Harvard Business School found that families with CHIP saw a 23 percent higher rate of self-employment and a 31 percent higher rate of ownership of incorporated businesses.



Families with CHIP saw an increase in self-employment and small business ownership.

KidsCare results in cost savings.

Researchers at ASU found that uninsured children avoid regular medical care resulting in costly emergency room use. Currently, Arizona children in the KidsCare family income range are more likely than other children to be uninsured.

KidsCare works hand-in-hand with private health plans.

KidsCare contracts with private health plans. Children covered by CHIP tend to be sicker than those covered by commercial plans, which means that commercial insurance risk pools may be stronger with KidsCare.

KidsCare has no impact on the state budget and will strengthen Arizona's healthcare system.

CoverKids COALITION

Organizations Supporting Reinstatement of KidsCare

AARP, Arizona
Adelante Health Care
Agave Pediatrics
American Academy of Pediatrics, Arizona
Arizona AFL-CIO
Arizona Alliance of Community Health Centers
Arizona Alliance for Retired Americans
Arizona Association for Foster and Adoptive Parents
Arizona Association of Providers for People with Disabilities
Arizona Asthma Coalition
Arizona Autism Coalition
Arizona Coalition to End Homelessness
Arizona Coalition to End Sexual and Domestic Violence
Arizona Community Action Association
Arizona Council of Human Service Providers
Arizona Dental Association
Arizona Family Health Partnership
Arizona Friends of Foster Children Foundation
Arizona Grandparent Ambassadors
Arizona Hospitals and Healthcare Association
Arizona Medical Association
Arizona Osteopathic Medical Association
Arizona Partnership for Infant Immunization
Arizona Public Health Association
Arizona Public Interest Research Group (PIRG)
Arizona Rural Health Association
Arizona School Boards Association
Association of Arizona Food Banks
Association for Supportive Child Care
Bayless Healthcare Group
Canyon Pediatrics
Casa de los Niños
Catholic Community Services
Chicanos Por La Causa
Child Crisis Arizona
Children's Action Alliance
Children's Cancer Network
Children's Clinics for Rehabilitative Services
Child and Family Resources
Coconino Coalition for Children and Youth
Cover Kids Coalition
David's Hope
Empowered Educators
Empowerment Systems
Father Matters
Flagstaff Chapter - AEA, Retired
Frameshift Group
Greater Phoenix Urban League
Hardge Consulting and Management, LLC
Health System Alliance of Arizona
The IDEA School
Jewish Family & Children's Services
Jordan Developmental Pediatrics
Keogh Health Connection
Kool Smiles, General Dentistry for Kids and Parents
Literacy Connects
Make Way for Books

List continued on next page

March of Dimes, Arizona Chapter
Maricopa County NAACP
Mending Hearts Family Services, Inc.
Mental Health America of Arizona
Mental Health Guild, Inc.
MHC Healthcare
The Monsignor Edward J. Ryle Fund
Mountain Park Health Center
National Association of Social Workers, Arizona Chapter
Outer Limits School
Phoenix Day
Pima County Access Program
Pima County Pediatric Society
Pima County - Tucson Women's Commission
Prevent Child Abuse Arizona
Protecting Arizona's Family Coalition
Raising Special Kids
Scottsdale UMC
Shepherd's Fold Preschool and Day Care
Society of St. Vincent de Paul
Southern Arizona Association for the Education of Young Children (SAzAEYC)
Southern Arizona Grandparent Ambassadors
Southwest Autism Research & Resource Center (SARRC)
Southwest Human Development
Spiritual Center
Stanley Gering, MD
St. Luke's Health Initiatives
St. Vincent de Paul/St. Mary's Conference
United Way of Tucson and Southern Arizona
Valdez Travel, Inc.
Valle del Sol
Valley of the Sun United Way
Valley Interfaith Project
West Valley Pediatrics
West Valley Neighborhoods Coalition
Women's Health Coalition
Yuma Community Food Bank

HOUSE OF REPRESENTATIVES

HB 2179

critical health information; emergency responders
Prime Sponsor: Representative Gabaldón, et al., LD 2

DP Committee on Transportation and Infrastructure

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HB 2179 allows a city, town or county to establish a program which provides emergency responders with critical health information about individuals who participate in the program by ordinance.

PROVISIONS

1. Permits a city, town or county to establish, by ordinance, a program which provides emergency responders with critical health information about individuals who participate in the program in order for emergency responders to aid participants who are involved in motor vehicle accidents or emergencies.

2. Outlines standards of such a program for a city, town or county as follows:
   a. Requires an interested party (including local law enforcement agencies, fire departments and emergency medical services personnel) to consult with each other and design program materials, giving consideration to similar programs in other states for the purpose of uniformity. The program materials must include all of the following:
      i. A yellow decal of uniform size and design that is to be placed on the rear driver's side window.
      ii. A health information card that provides a recent photograph of the participant and indicate their name, emergency contact information, physician's names and contact information, medical conditions, recent surgeries, allergies, medications and any other information the city, town or county deems relevant.
      iii. A yellow envelope for the health information card to be inserted into and placed in the participant's glove compartment.
   b. Mandates the city, town or county to provide program materials to the public and to state and local law enforcement agencies.
   c. Allows the city, town or county to charge a participant a fee which will be determined by the local entity.

3. Provides that a yellow decal on a motor vehicle involved in a vehicle accident or emergency:
   a. Serves as a notification to an emergency responder that the driver or any of the passengers may be a program participant.
   b. Authorizes the responding emergency provider to search the glove compartment for the yellow program envelope.

4. Allows the emergency provider to use the information contained in the yellow envelope for the following purposed:
   a. To identify the program participant.
   b. To determine whether the program participant has a medical condition that could impede communications with the emergency responder.
   c. To communicate with the program participant's emergency contacts about the condition and location of the participant.
   d. To consider the program participant's current medications or preexisting conditions when treatment is administered.
5. States that an emergency responder is not liable for civil damages resulting from acts or omissions that do not amount to wilful misconduct or gross negligence in response to incomplete, incorrect or outdated information provided on a health information card if the responder acted in good faith in the execution of care.
6. States that an emergency responder is not liable for damage to a program participant's vehicle when obtaining information if the participant is unresponsive.
7. Defines *emergency responder* and *program participant.*

CURRENT LAW

Currently not addressed in statute.

Fifty-second Legislature
Second Regular Session

Health
H.B. 2179

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2179

(Reference to printed bill)

Page 1, line 19, strike "OF A UNIFORM SIZE AND DESIGN" insert "WITH A DIAMETER OF THREE AND ONE-HALF INCHES THAT READS "SAVING LIVES" IN ITS CENTER, AND AN OPTIONAL ONE-HALF INCH BORDER LISTING THE ISSUING CITY, TOWN OR COUNTY,"

Amend title to conform

RANDALL FRIESE

2179FRIESE2
02/05/2016
04:02 PM
H: CA/rca

Attachment 11

Adopted ✓ # of Verbals _____
Failed _____ Withdrawn _____
Not Offered ____ Analysts Initials ___

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2179

DATE February 9, 2016 MOTION: dpa

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 12

HOUSE OF REPRESENTATIVES

HB 2264

insurance; prescription eye drops; refills
Prime Sponsor: Representative Brophy McGee, et al., LD 28

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HB 2264 prohibits a corporation, a health care services organization, a disability insurer or a group or blanket disability insurer that provides coverage for prescriptions of eye drops from denying coverage for a refill of a prescription for eye drops when all conditions are met.

PROVISIONS

1. States that any contract by a corporation, any evidence of coverage by a health care services organization, any policy by a disability insurer or any policy by a group or blanket disability insurer that is issued, delivered or renewed on or after the effective date of this section and provides coverage for prescription eye drops may not deny coverage for a refill of a prescription for eye drops if all of the following apply:
   a. The subscriber, enrollee or insured requests the refill:
      i. For a 30 day supply, at least 21 days and less than 30 days from the later of:
         - The original date that the prescription was distributed to the subscriber, the enrollee or the insured; or
         - The date of the most recent refill that was distributed to the subscriber, the enrollee or the insured.
      ii. For a 60 day supply, at least 42 days and less than 60 days from the later of:
         - The original date that the prescription was distributed to the subscriber, the enrollee or the insured; or
         - The date of the most recent refill that was distributed to the subscriber, the enrollee or the insured.
      iii. For a 90 day supply, at least 63 days and less than 90 days from the later of:
         - The original date that the prescription was distributed to the subscriber, the enrollee or the insured; or
         - The date of the most recent refill that was distributed to the subscriber, the enrollee or the insured.
   b. The prescription eye drops prescribed by the health care provider are a covered benefit under the subscriber's, enrollee's or insured's contract;
   c. The prescribing health care provider indicates on the original prescription that additional quantities of the prescription eye drops are needed; and
   d. The refill requested by the subscriber, the enrollee or the insured does not exceed the number of additional quantities prescribed.
2. States to the extent practicable, the requirements of this section are limited in quantity to the remaining dosage initially approved for coverage, except that any limited refilling may not limit or restrict coverage to any previously or subsequently approved prescription eye drops

and is subject to the terms and conditions of the contract, evidence of coverage or policy that are applicable to the coverage.

CURRENT LAW

Not currently addressed in statute.

Fifty-second Legislature
Second Regular Session

Health
H.B. 2264

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2264

(Reference to printed bill)

Page 1, lines 7 and 8, after "DROPS" insert "TO TREAT GLAUCOMA AND OCULAR HYPERTENSION"

Line 10, strike "TWENTY-ONE" insert "TWENTY-THREE"

Line 16, strike "FORTY-TWO" insert "FORTY-FIVE"

Line 22, strike "SIXTY-THREE" insert "SIXTY-EIGHT"

Lines 28, 31 and 38, after "DROPS" insert "TO TREAT GLAUCOMA AND OCULAR HYPERTENSION"

Page 2, lines 1 and 2, after "DROPS" insert "TO TREAT GLAUCOMA AND OCULAR HYPERTENSION"

Line 5, strike "TWENTY-ONE" insert "TWENTY-THREE"

Line 11, strike "FORTY-TWO" insert "FORTY-FIVE"

Line 17, strike "SIXTY-THREE" insert "SIXTY-EIGHT"

Lines 23, 26, 33 and 41 after "DROPS" insert "TO TREAT GLAUCOMA AND OCULAR HYPERTENSION"

Line 44, strike "TWENTY-ONE" insert "TWENTY-THREE"

Page 3, line 5, strike "FORTY-TWO" insert "FORTY-FIVE"

Line 11, strike "SIXTY-THREE" insert "SIXTY-EIGHT"

Lines 17, 20, 27 and 34, after "DROPS" insert "TO TREAT GLAUCOMA AND OCULAR HYPERTENSION"

Line 37, strike "TWENTY-ONE" insert "TWENTY-THREE"

Line 43, strike "FORTY-TWO" insert "FORTY-FIVE"

Attachment 14

Adopted ✓ # of Verbals _____
Failed _____ Withdrawn _____
Not Offered _____ Analysts Initials _____

House Amendments to H.B. 2264

Page 4, line 5, strike "SIXTY-THREE" insert "SIXTY-EIGHT"

Lines 10, 13 and 20 after "DROPS" insert "TO TREAT GLAUCOMA AND OCULAR HYPERTENSION"

Amend title to conform

HEATHER CARTER

2264CARTER
02/08/2016
11:26 AM
H: ig/ajh

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2264

DATE February 9, 2016 MOTION: do pa

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 15

HOUSE OF REPRESENTATIVES

HB 2503

psychologists; licensure compact
Prime Sponsor: Representative Carter, LD 15

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HB 2503 enacts the Psychologists Licensure Compact (Compact).

PROVISIONS

Purpose

1. States that this Compact is designed to achieve the following purposes and objectives:
   a. Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state where the psychologist is not licensed to practice psychology;
   b. Enhance the states' ability to protect the public's health and safety, especially client/patient safety;
   c. Encourage the cooperation of Compact states in the areas of psychology licensure and regulation;
   d. Facilitate the exchange of information between Compact states regarding psychologist licensure, adverse actions and disciplinary history;
   e. Promote compliance with the laws governing psychological practice in each Compact state; and
   f. Invest all Compact states with the authority to hold licensed psychologists accountable through the mutual recognition of Compact state licenses.

Home State Licensure

2. Specifies that the home state must be a Compact state where a psychologist is licensed to practice psychology.
3. Allows for a psychologist to hold one or more Compact state licenses at a time. If the psychologist is licensed in more than one Compact state, the home state is the Compact state where the psychologist is physically present when the services are delivered as authorized by the authority to practice interjurisdictional telepsychology under the terms of this Compact.
4. States that any Compact state may require a psychologist who has not been previously licensed in a Compact state to obtain and retain a license to be authorized to practice in the Compact state under circumstances not authorized by the authority to practice interjurisdictional telepsychology under this Compact.
5. Provides that any Compact state may require a psychologist to obtain and retain a license to practice in the Compact state under circumstances not authorized by temporary authorization to practice under the terms of this Compact.

6. Authorizes a psychologist with a home state license to practice interjurisdictional telepsychology in a receiving state only if the Compact state:
   a. Requires the psychologist to hold an active E. Passport;
   b. Has a mechanism in place for receiving and investigating complaints about licensed individuals;
   c. Notifies the Psychology Interjurisdictional Compact Commission (Commission) of any adverse action or significant investigatory information regarding a licensed individual;
   d. Requires an identity history summary of all applicants at initial licensure, including the use of the results of fingerprints or other data checks compliant with the Federal Bureau of Investigation or other designee with similar authority no later than ten years after activation of the Compact; and
   e. Complies with the rules and bylaws of the Commission.
7. Grants a psychologist that has a home state license temporary authorization to practice in a distant state only if the Compact state does the following:
   a. Requires the psychologist to hold an active Interjurisdictional Practice Certificate (IPC);
   b. Has a mechanism in place for receiving and investigating complaints about licensed individuals;
   c. Notifies the Commission of any adverse action or significant investigatory information regarding a licensed individual;
   d. Requires an identity history summary of all applicants at initial licensure, including the use of the results of fingerprints or other data checks compliant with the requirements of the Federal Bureau of Investigation or another designee with similar authority no later than ten years after activation of the Compact; and
   e. Complies with the bylaws and rules of the Commission.

Compact Privilege to Practice Telepsychology

8. Requires Compact states to recognize the right of a psychologist who is licensed in a Compact state to practice telepsychology in other Compact states or receiving states in which the psychologist is not licensed to practice interjurisdictional telepsychology.
9. Specifies that a psychologist licensed to practice in a Compact state and exercise the authority to practice interjurisdictional telepsychology under the terms and provisions of this Compact must:
   a. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:
      i. Regionally accredited by an accrediting body recognized by the United States Department of Education to grant graduate degrees or authorized by provincial statute or royal charter to grant doctoral degrees; or
      ii. A foreign college or university deemed to be equivalent by a foreign credential evaluation service that is a member of the national association of credential evaluation services or by a recognized foreign credential evaluation service; and
   b. Hold a graduate degree in psychology that meets the following criteria:
      i. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
      ii. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

iii. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;
iv. The program must consist of an integrated, organized sequence of study;
v. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
vi. The designated director of the program must be a psychologist and a member of the core faculty;
vii. The program must have an identifiable body of students who are matriculated in that program for a degree;
viii. The program must include supervised practicum, internship or field training appropriate to the practice of psychology;
ix. The curriculum must encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;
x. The program includes an acceptable residency as defined by the rules of the Commission.

c. Possess a current, full and unrestricted license to practice psychology in a home state that is a Compact state;
d. Have no history of adverse action that violates the rules of the Commission;
e. Have no criminal record history reported on an identity history summary that violates the rules of the Commission;
f. Possess a current, active E.Passport;
g. Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
h. Meet other criteria as defined by the rules of the Commission.

10. Requires a psychologist practicing in a receiving state to practice within areas of competencies and the scope of practice authorized by the home state.

11. Specifies that a psychologist practicing in a receiving state be subject to the home state's authority and laws. A receiving state may limit or revoke a psychologist's authority to practice interjurisdictional telepsychology in the receiving state and may take necessary actions to protect the health and safety of the receiving state's citizens. If a receiving state takes action, the state must promptly notify the home state and Commission.

12. Revokes a psychologist's E. Passport in a Compact state if their home state license is restricted, suspended or limited and the psychologist will not be eligible to practice telepsychology in that Compact state.

Compact Temporary Authorization to Practice

13. Requires Compact states to recognize the right of a psychologist who is licensed in a Compact state to practice temporarily in other Compact states or distant states in which the psychologist is not licensed as approved in the Compact.

14. Permits a psychologist to exercise temporary authorization to practice in a Compact state by meeting the following requirements:
    a. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

i. Regionally accredited by an accrediting body recognized by the United States Department of Education to grant graduate degrees, or authorized by provincial statute or royal charter to grant doctoral degrees; or
ii. A foreign college or university deemed to be equivalent by a foreign credential evaluation service that is a member of the national association of credential evaluation services or by a recognized foreign credential evaluation service; and

b. Hold a graduate degree in psychology that meets the following criteria:
i. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
ii. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;
iii. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;
iv. The program must consist of an integrated, organized sequence of study;
v. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
vi. The designated director of the program must be a psychologist and a member of the core faculty;
vii. The program must have an identifiable body of students who are matriculated in that program for a degree;
viii. The program must include supervised practicum, internship or field training appropriate to the practice of psychology;
ix. The curriculum must encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;
x. The program includes an acceptable residency as defined by the rules of the Commission;

c. Possess a current, full and unrestricted license to practice psychology in a home state that is a Compact state;
d. Have no history of adverse action that violates the rules of the Commission;
e. Have no criminal record history that violates the rules of the Commission;
f. Possess a current, active IPC;
g. Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
h. Meet other criteria as defined by the rules of the Commission.

15. Requires a psychologist who practices in a distant state under temporary authorization to practice within the scope of practice authorized by that distant state.

16. States that a psychologist practicing in a distant state must be subject to the distant state's authority and law. A distant state may limit or revoke a psychologist's temporary authorization to practice in that state and may take other necessary actions to protect the health and safety of the citizens. If a distant state takes action, the state must promptly notify the home state and the Commission.

17. Revokes a psychologist's IPC if their license in any home state, Compact state or any other temporary authorization to practice in any distant state is restricted, suspended or limited.

Conditions of Telepsychology Practice in a Receiving State

18. Allows a psychologist to practice in a receiving state only if the psychologist initiates client/patient contact in a home state via telecommunications technologies with a client/patient in a receiving state or other conditions regarding telepsychology as determined by rules promulgated by the Commission.

Adverse Actions

19. Gives the home state power to impose adverse action against a psychologist's license issued by the home state. A distant state must have the power to take adverse action on a psychologist's temporary authorization to practice within that distant state.
20. Permits a receiving state to take adverse action on a psychologist's authority to practice interjurisdictional telepsychology within that receiving state. A home state may take adverse action against a psychologist based on an adverse action taken by a distant state regarding temporary in person, face-to-face practice.
21. Authorizes a home state to terminate a psychologist's authority to practice and revoke their E. Passport if the home state takes adverse action against a psychologist's license.
22. States that if a home state takes adverse action against a psychologist's license, that psychologist's authority to practice interjurisdictional telepsychology is terminated and the E. passport is revoked. A psychologist's temporary authorization to practice is terminated and the IPC is revoked as follows:
    a. All home state disciplinary orders that impose adverse action must be reported to the Commission in accordance with the rules promulgated by the Commission. A Compact state must report adverse actions in accordance with the rules of the Commission.
    b. In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in person, face-to-face practice in accordance with the rules of the Commission.
    c. Other actions may be imposed as determined by the rules of the Commission.
23. Requires the home state's psychology regulatory authority to investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee that occurred in a receiving state as it would if the conduct had occurred in the home state. Home state's law must control the determination of any adverse action against a psychologist's license.
24. Requires a distant state's psychology regulatory authority to investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under temporary authorization which occurred in that distant state as it would if the conduct occurred within the home state. A distant state's law must control the determination of any adverse action against a psychologist's temporary authority to practice.
25. Clarifies that a Compact state's decision for a psychologist to participate in an alternative program may be used in lieu of adverse action and that participation must remain nonpublic if required by the Compact state's law. Compact states must require psychologists not to provide telepsychology services or provide temporary psychological services in any other Compact state during the term of the alternative program.
26. Mandates that no other judicial or administrative remedies be available to a psychologist in the event a Compact state imposes an adverse action.

Additional Authorities Invested in a Compact State's Psychology Regulatory Authority

27. Allows for a Compact state's psychology regulatory authority to have additional powers and authorities under the Compact to do the following:
    a. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas must be enforced in the latter state by any court of competent jurisdiction. The issuing state must pay witness fees, travel expenses, mileage and other required fees; and
    b. Issue cease and desist or injunctive relief orders to revoke a psychologist's authority to practice interjurisdictional telepsychology and/or temporary authorization to practice.
28. States that a psychologist, during the course of an investigation, may not change the psychologist's home state licensure. A home state's psychology regulatory authority is authorized to complete any pending investigations of a psychologist and take any actions deemed necessary under its law. The home state's psychology regulatory authority must promptly report the findings of the investigations to the Commission.
29. Permits the psychologist to change their home state licensure once any investigations have been completed. The Commission must promptly notify the new home state and all information provided to the Commission or distributed by Compact states must be confidential, filed under seal and used for investigatory or disciplinary purposes. The Commission may create additional rules for mandated or discretionary sharing of information by Compact states.

Coordinated Licensure Information System

30. Requires the Commission to provide for the development and maintenance of a coordinated database and reporting system that contains licensure and disciplinary action information on all psychologists or individuals to whom this Compact applies to.
31. States that a Compact state must submit a uniform data set to the coordinated database on all licensees including the following requirements;
    a. Identifying information;
    b. Licensure data;
    c. Significant investigatory information;
    d. Adverse actions against a psychologist's license;
    e. An indicator that a psychologist's authority to practice interjurisdictional telepsychology and/or temporary authorization to practice is revoked;
    f. Non-confidential information related to alternative program participation information;
    g. Any denial of application for licensure and the reasons for the denial; and
    h. Other information that may facilitate the administration of this Compact as determined by the rules of the Commission.
32. Mandates the coordinated database administrator must promptly notify all Compact states of any adverse action taken against or significant investigative information on any licensee in a Compact state.
33. States that Compact state's reporting information to the coordinated database may designate information that may not be shared with the public without the express permission of the Compact state reporting the information.

34. Requires for any information that is submitted to the coordinated database that is subsequently required to be expunged by the law of the Compact state reporting the information be removed from the coordinated database.

Establishment of the Psychology Interjurisdictional Compact Commission

35. Creates a joint public agency known as the Psychology Interjurisdictional Compact Commission as follows:
    a. The Commission is a body politic and an instrumentality of the Compact states;
    b. Venue is proper and judicial proceedings by or against the Commission must be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings; and
    c. Nothing in this Compact must be construed to be a waiver of sovereign immunity.

36. Establishes membership, voting and meetings requirements as follows:
    a. The Commission must consist of one voting representative appointed by each Compact state who must serve as that state's commissioner. The state psychology regulatory authority must appoint its delegate. This delegate must be empowered to act on behalf of the Compact state. This delegate must be limited to:
        i. The executive director or executive secretary or a similar executive;
        ii. A current member of the state psychology regulatory authority of a Compact state; or
        iii. A designee empowered with the appropriate delegate authority to act on behalf of the Compact state.
    b. Any commissioner may be removed or suspended from office as provided by the law of the state from which the commissioner is appointed. Any vacancy occurring in the Commission will be filled in accordance with the laws of the Compact state in which the vacancy exists.
    c. Each commissioner must be entitled to one vote with regard to the promulgation of rules and creation of bylaws and must otherwise have an opportunity to participate in the business and affairs of the Commission. A commissioner must vote in person or by such other means as provided in the bylaws. The bylaws may provide for commissioners' participation in meetings by telephone or other means of communication.
    d. The Commission must meet at least once during each calendar year. Additional meetings will be held as set forth in the bylaws.
    e. All meetings must be open to the public, and public notice of meetings will be given.
    f. The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:
        i. Noncompliance of a Compact state with its obligations under the Compact;
        ii. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
        iii. Current, threatened or reasonably anticipated litigation against the Commission;
        iv. The negotiation of contracts for the purchase or sale of goods, services or real estate;
        v. An accusation against any person of a crime or formally censuring any person;
        vi. The disclosure of trade secrets or commercial or financial information that is privileged or confidential;
        vii. The disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

viii. The disclosure of investigatory records compiled for law enforcement purposes;
ix. The disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or another committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or
x. Matters specifically exempted from disclosure by federal and state statute.

g. If a meeting, or portion of a meeting, is closed, the Commission's legal counsel must certify that the meeting may be closed and reference each relevant exempting provision. The Commission must keep minutes that fully and clearly describe all matters discussed in a meeting and must provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons, including a description of the views expressed. All documents considered in connection with an action must be identified in the minutes. All minutes and documents of a closed meeting must remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

37. Permits the Commission to prescribe bylaws or rules to govern its conduct to carry out the purposes and exercise the powers of the Compact by a majority vote of the commissioners including:
a. Establishing the fiscal year of the Commission;
b. Providing reasonable standards and procedures:
i. For the establishment and meetings of other committees; and
ii. Governing any general or specific delegation of any authority or function of the Commission.
c. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with exceptions designed to protect the public's interest, the privacy of individuals of such proceedings and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each commissioner with no proxy votes allowed;
d. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;
e. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact state, the bylaws must exclusively govern the personnel policies and programs of the Commission;
f. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees;
g. Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact and after the payment and/or reserving of all of its debts and obligations;
h. The Commission must publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compact states;
i. The Commission must maintain its financial records in accordance with the bylaws; and

j. The Commission must meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

38. Designates powers to the Commission as follows:
    a. To promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rule must have the force and effect of law and must be binding in all Compact states;
    b. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state psychology regulatory authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law must not be affected;
    c. To purchase and maintain insurance and bonds;
    d. To borrow, accept or contract for services of personnel, including employees of a Compact state;
    e. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;
    f. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same, provided that at all times the Commission must strive to avoid any appearance of impropriety or conflict of interest;
    g. To lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or use, any property, real, personal or mixed, provided that at all times the Commission must strive to avoid any appearance of impropriety;
    h. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;
    i. To establish a budget and make expenditures;
    j. To borrow money;
    k. To appoint committees, including advisory committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;
    l. To provide and receive information from, and to cooperate with, law enforcement agencies;
    m. To adopt and use an official seal; and
    n. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice and telepsychology practice.

39. Mandates that elected officers serve as the executive board which must have the power to act on behalf of the Commission according to the following terms:
    a. The executive board shall be composed of the following six members:
        i. Five voting members who are elected from the current membership of the Commission by the Commission;
        ii. One ex officio, nonvoting member from the recognized membership organization composed of state and provincial psychology regulatory authorities.
    b. The ex officio member must have served as staff with or a member on a state psychology regulatory authority and must be selected by its respective organization;
    c. The Commission may remove any member of the executive board as provided in bylaws;

d. The executive board must meet at least annually;
e. The executive board must have the following duties and responsibilities:
   i. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact, fees paid by Compact states such as annual dues, and any other applicable fees;
   ii. Ensure Compact administration services are appropriately provided, contractual or otherwise;
   iii. Prepare and recommend the budget;
   iv. Maintain financial records on behalf of the Commission;
   v. Monitor Compact compliance of member states and provide compliance reports to the Commission;
   vi. Establish additional committees as necessary; and
   vii. Other duties as provided in rules or bylaws.

40. Outlines the financial structure of the Commission as follows:
   a. The Commission must pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities;
   b. The Commission may accept any and all appropriate revenue sources, donations and grants of money, equipment, supplies, materials and services;
   c. The Commission may levy on and collect an annual assessment from each Compact state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based on a formula to be determined by the Commission, which must promulgate a rule binding on all Compact states;
   d. The Commission must not incur obligations of any kind prior to securing the funds adequate to meet the same, nor must the Commission pledge the credit of any of the Compact states, except by and with the authority of the Compact state;
   e. The Commission must keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission must be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the Commission.

41. Provides qualified immunity, defense and indemnification provisions as follows:
   a. The members, officers, executive director, employees and representatives of the Commission must be immune from suit and liability, either personally or in their official capacity for any claim for damage or loss of property or personal injury caused by or arising out of any actual or alleged act, error, omission or that the person against whom the claim has been made had a reasonable basis for believing such occurrences happened. Duties and responsibilities must protect any such person from suit or liability caused by intentional, wilful or wanton misconduct.
   b. The Commission must defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or that the person against whom the claim is made had a reasonable basis for believing such occurrences happens. Allows for nothing to

prohibit that person from retaining their own counsel and the act did not result from that person's intentional, wilful or wanton misconduct.

c. The Commission must indemnify and hold harmless any member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of the Commission employment or duties if the act did not result from intentional, wilful or wanton misconduct.

Rulemaking

42. Mandates that the Commission exercise its rulemaking powers and that all the rules and amendments must become binding as of the date specified in each rule or amendment.

43. States that if a majority of the legislatures of the Compact states reject a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, that rule will have no further force and effect in any Compact state.

44. Requires for rules or amendments to rules to be adopted at a regular or special meeting of the Commission.

45. Mandates that rules or amendments to the rules must be adopted at a regular or special meeting of the Commission, and at least sixty days in advance of the meeting at which the rule will be considered and voted on, the Commission must file a notice of proposed rulemaking as follows:
    a. On the website of the Commission; and
    b. On the website of each Compact state's psychology regulatory authority or the publication in which each state would otherwise publish proposed rules.

46. Outlines the contents and notice of proposed rulemaking to include:
    a. The proposed time, date and location of the meeting in which the rule will be considered and voted on;
    b. The text of the proposed rule or amendment and the reason for the proposed rule;
    c. A request for comments on the proposed rule from any interested person; and
    d. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

47. Allows the Commission to let people submit written data, facts, opinions and arguments prior to adopting a proposed rule which must be made available to the public.

48. Mandates the Commission to grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:
    a. At least twenty-five people who submit comments that are independent of each other;
    b. A governmental subdivision or agency; or
    c. A duly appointed person in an association that has at least twenty-five members.

49. Requires the Commission to publish the place, time and date of a scheduled public hearing and the following to apply to a hearing:
    a. All persons wishing to be heard at the hearing must notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing;
    b. Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing;

c. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This paragraph does not preclude the Commission from making a transcript or recording of the hearing if it so chooses;
d. Nothing in this subsection shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this subsection.

50. States that following a scheduled hearing date or by the close of business on the scheduled hearing date, if the hearing was not held, the Commission must consider all written and oral comments that were received.

51. Requires the Commission by majority vote of all members to take final action on a proposed rule and determine the effective date of the rule based on the rulemaking record and the full text of that rule.

52. Gives the Commission the opportunity to proceed with promulgation of the proposed rule without a public hearing if no written notice of intent to attend the public hearing by interested parties is received.

53. Allows the Commission to consider and adopt an emergency rule, if an emergency exists, without prior notice or opportunity for comment or hearing, provided that the rulemaking procedures provided in the Compact are retroactively applied to the rule as soon as reasonably practicable but no later than 90 days after the effective date of the rule. An emergency rule is one that must be adopted immediately in order to:
a. Meet an imminent threat to public health, safety or welfare;
b. Prevent a loss of Commission or Compact state funds;
c. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or
d. Protect public health and safety.

54. Allows the Commission or any authorized committee of the Commission to make direct revisions to a previously adopted rule or amendment for purposes of correcting typographical, format or grammatical errors. Public notice of any revision must be posted on the Commission's website.

55. Mandates a revision must be subject to challenge by any person for a period of 30 days after posting and may be challenged only on grounds that the revision results in a material change to a rule.

56. Specifies that a challenge must be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action and if there is a challenge, the revision may not take effect without the approval of the Commission.

Oversight, Dispute Resolution and Enforcement

57. Outlines the oversight of the Commission as follows:
a. The executive, legislative and judicial branches of government in each Compact state must enforce this Compact and take all actions necessary to effectuate the Compact's purpose and intent.

b. All courts must take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact state pertaining to any subject matter that may affect the powers, responsibilities or actions of the Commission
c. The Commission must be entitled to receive service of process in any proceeding and must have standing to intervene in a proceeding. Failure to provide service of process to the Commission will render a judgment as to the Commission.

58. States default, technical assistance and termination provisions as follows:
    a. If the Commission determines that a Compact state has defaulted in the performance of its obligations or responsibilities under this Compact or promulgated rules the Commission must:
        i. Provide written notice to the defaulting state and other Compact states of the nature of the default, the proposed means of remedying the default or any other action taken by the Commission; and
        ii. Provide remedial training and specific technical assistance regarding the default.
    b. If a state that is in default fails to remedy the default, the defaulting state may be terminated from the Compact on an affirmative vote of a majority of the Compact states. All rights, privileges and benefits by this Compact must be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of any obligation or liabilities;
    c. Termination of membership in the Compact must be imposed after all other means of securing compliance have been met. Notice of intent to suspend or terminate must be submitted by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature and each of the Compact states;
    d. A Compact state that has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination including obligations that extend beyond the effective date of termination;
    e. The Commission must not bear any costs incurred by the state that is found to be in default or that has been terminated from the Compact unless agreed upon in writing between the Commission and the defaulting state; and
    f. The defaulting state may appeal the action of the Commission by petitioning the United States District Court for the State of Georgia or the Federal District where the Compact has its principal offices. The prevailing member must be awarded all costs of the litigation including reasonable attorney's fees.

59. Outlines dispute resolution provision as follows:
    a. On request by a Compact state, the Commission must attempt to resolve disputes related to the Compact which arise among Compact states and between Compact and non-compact states; and
    b. The Commission must promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

60. Gives enforcement provisions and rules of this Compact as follows:
    a. The Commission, in the reasonable exercise of its discretion, must enforce the provisions and rules of this Compact;
    b. By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the Federal District where the Compact has its principal offices against a Compact state in default to enforce compliance with the provisions of the Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the

prevailing member must be awarded all costs of such litigation, including reasonable attorney's fees; and

c. The remedies are not the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

Date of Implementation of the Commission and Associated Rules, Withdrawal and Amendments

61. Establishes that the Compact take effect on the date on which the Compact is enacted into law in the seventh Compact state. The effective provisions must be limited to the powers granted to the Commission relating to the assembly and promulgation of rules. The Commission must meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

62. Mandates that any state that joins the Compact subsequent to the Commission's initial adoption of the rules must be subject to the rules as they exist on the date when the Compact becomes a law in that state. Any rule that is previously adopted by the Commission must have the full force and effect of law on the day the Compact becomes law.

63. Allows for a Compact state to withdraw from this Compact by enacting a repealing statute and is subject to the following:
    a. A Compact state's withdrawal must not take effect until six months after enactment of the repealing statute; and
    b. Withdrawal must not affect the continuing requirement of the withdrawing state's psychology regulatory authority to comply with the investigative and adverse action reporting requirements of this Compact before the date of withdrawal.

64. States that the Compact must not be construed to invalidate or prevent any psychology licensure agreement or other arrangement between a Compact state and a non-compact state that does not conflict with the provisions of this Compact.

65. Allows for the Compact to be amended by the compact states and makes no amendment to this Compact effective and binding on the Compact states until it is enacted into the law of all Compact states.

Construction and Severability

66. Makes this Compact liberally construed so as to effectuate the purposes. If the Compact is held contrary to the constitution of any state member the Compact remains in full force and effect as to the remaining Compact states.

Other

67. Defines terms.

CURRENT LAW

Contained within Title 32, Chapter 19.1 are the laws relating to the practice of psychology. Included therein are licensing and education requirements along with applicable regulations.

HB 2503
Carter Verbal Amendment to the Printed Bill
2/9/16

Page 7 Line 7 strike, "HOME" insert "RECEIVING"

Attachment 17

Adopted ✓ # of Verbals 1 ✓

Failed _____ Withdrawn_____

Not Offered____ Analysts Initials ___

Fifty-second Legislature
Second Regular Session

Health
H.B. 2503

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2503

(Reference to printed bill)

Page 7, strike lines 1 through 4, insert:

"C. THE HOME STATE MAINTAINS AUTHORITY OVER THE LICENSE OF THE PSYCHOLOGIST PRACTICING INTO A RECEIVING STATE UNDER THE AUTHORITY TO PRACTICE TELEPSYCHOLOGY."

Line 7, strike "AUTHORITY AND LAWS" insert "SCOPE OF PRACTICE"

Amend title to conform

HEATHER CARTER

2503CARTER
02/08/2016
10:00 AM
C: MJH

Attachment 18

Adopted ✓ # of Verbals _____
Failed _____ Withdrawn _____
Not Offered ____ Analysts Initials ___

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2503

DATE February 9, 2016 MOTION: dpa

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelly
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

HOUSE OF REPRESENTATIVES

HB 2504

revenue department; technical correction
Prime Sponsor: Representative Carter, LD 15

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HB 2504 makes a technical correction.

Summary of Proposed Strike-Everything Amendment to HB 2504

HB 2504 enacts the Physical Therapy Licensure Compact (Compact).

PROVISIONS

Purpose

1. Explains the purpose of the Compact is to facilitate the interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of the states to protect public health and safety through the current system of state licensure. The Compact is designed to achieve the following objectives:
   a. Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses;
   b. Enhance the states' ability to protect the public's health and safety;
   c. Encourage the cooperation of member states in regulating multi-state physical therapy practice;
   d. Support spouses of relocating military members;
   e. Enhance the exchange of licensure, investigative and disciplinary information between member states; and
   f. Allow a remote state to hold a provider of services with a Compact privilege in that state accountable to that state's practice standards.

State Participation in the Compact

2. Outlines requirements for states' participation in the Compact as follows:
   a. Participate fully in the Physical Therapy Compact Commission's (Commission) data system, including using the Commission's unique identifier as defined in rules;
   b. Have a mechanism in place for receiving and investigating complaints about licensees;
   c. Notify the Commission, in compliance with the terms of the Compact and rules, of any adverse action or the availability of investigative information regarding a licensee;
   d. Fully implement a criminal background check requirement, within a time frame established by rule, by receiving the results of the Federal Bureau of Investigation (FBI) record search on criminal background checks and use the results in making licensure decision;

e. Comply with the rules of the Commission;
f. Utilize a recognized national examination as a requirement for licensure pursuant to the rules of the Commission; and
g. Have continuing competence requirements as a condition for license renewal.

3. Requires the member state to have the authority to obtain biometric-based information from each physical therapy licensure applicant and submit the information to the FBI for a criminal background check upon the adoption of this statute.

4. Mandates a member state to grant the Compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the Compact and rules.

5. Permits member states to charge a fee for granting a Compact privilege.

Compact Privilege

6. Requires a licensee to meet the following requirements in order to have the right to exercise the Compact privilege:
   a. Hold a license in the home state;
   b. Have no encumbrance on any state license;
   c. Be eligible for a Compact privilege in any member state;
   d. Have no adverse action against any license or Compact privilege within the previous two years;
   e. Notify the Commission that the licensee is seeking the Compact privilege within a remote state(s);
   f. Pay any applicable fees, including any state fee, for the Compact privilege;
   g. Meet any jurisprudence requirements established by the remote state(s) in which the licensee is seeking a Compact privilege; and
   h. Report to the Commission adverse action taken by any non-member state within 30 days from the date the adverse action is taken.

7. States that the Compact privilege is valid until the expiration date of the home license and the licensee must comply with the above requirements above to maintain the Compact privilege in the remote state.

8. Mandates the licensee providing physical therapy in a remote state, under the Compact privilege, to function within the laws and regulations of the remote state.

9. Specifies that a licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's Compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a Compact privilege in any state until the specific time for removal has passed and all fines are paid.

10. Stipulates that if a home state license is encumbered, the licensee loses the Compact privilege in any remote state until the following occur:
    a. The home state license is no longer encumbered; and
    b. Two years have elapsed from the date of the adverse action.

11. States that once an encumbered license in the home state is restored to good standing, the licensee may again obtain a Compact privilege in any remote state.

12. Explains that if a licensee's Compact privilege in any remote state is removed, the individual loses the Compact privilege in any remote state until the following occur:
    a. The specific period of time for which the Compact privilege was removed has ended;
    b. All fines have been paid; and
    c. Two years have elapsed from the date of the adverse action.
13. Allows for a licensee to obtain a Compact privilege in a remote state if all requirements are met.

Active Duty Military Personnel or Their Spouses

14. Permits a licensee who is an active duty military member or the spouse of an individual who is an active duty military member to designate one of the following as the home state:
    a. A home of record;
    b. A permanent change of station (PCS); or
    c. The state of current residence if it is different than the PCS state or home of record.

Adverse Actions

15. Gives the home state exclusive power to impose adverse action against a license issued by the home state.
16. Allows a home state to take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.
17. Clarifies this Compact does not override a member state's decision to allow participation in an alternative program in lieu of adverse action and that such participation must remain non-public if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.
18. Permits any member state to investigate actual or alleged violations of the statutes and rules authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or Compact privilege.
19. Requires a remote state to have the authority to:
    a. Take adverse actions against a licensee's Compact privilege in the state;
    b. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, must be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority must pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and
    c. If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.
20. Allows a member state, in addition to the authorities granted to a member state by its respective physical therapy practice act or other applicable state law, to participate with other member states in joint investigations of licensees.

21. Requires a member state to share any investigative, litigation or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

Establishment of the Commission

22. Declares the Compact member states hereby create and establish a joint public agency known as the Commission as follows:
    a. The Commission is an instrumentality of the Compact states;
    b. Venue is proper and judicial proceedings by or against the Commission must be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings; and
    c. Nothing in this Compact must be construed to be a waiver of sovereign immunity.

23. Stipulates membership, voting and meetings as follows:
    a. Each member state must have and be limited to one delegate selected by that member state's licensing board;
    b. The delegate must be a current member of the licensing board, who is a physical therapist, physical therapist assistant, public member or the board administrator;
    c. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed;
    d. The member state board must fill any vacancy occurring in the Commission;
    e. Each delegate must be entitled to one vote with regard to the promulgation of rules and creation of bylaws and must otherwise have an opportunity to participate in the business and affairs of the Commission;
    f. A delegate must vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication; and
    g. The Commission must meet at least once during each calendar year and additional meeting must be held as set forth in the bylaws.

24. Gives the Commission the following powers and duties:
    a. Establish the fiscal year of the Commission;
    b. Establish bylaws;
    c. Maintain its financial records in accordance with the bylaws;
    d. Meet and take such actions as are consistent with the provisions of this Compact and the bylaws;
    e. Promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules must have the force and effect of law and must be binding in all member states;
    f. Bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law must not be affected;
    g. Purchase and maintain insurance and bonds;
    h. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state;
    i. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and to

establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

j. Accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same, provided that at all times the Commission must avoid any appearance of impropriety and/or conflict of interest;
k. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission must avoid any appearance of impropriety;
l. Sell covey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property real, personal or mixed;
m. Establish a budget and make expenditures;
n. Borrow money;
o. Appoint committees, including standing committees comprised of members, state regulators, state legislators or their representatives, consumer representatives and such other interested persons as may be designated in this Compact and the bylaws;
p. Provide and receive information from, and cooperate with, law enforcement agencies;
q. Establish and elect an Executive Board; and
r. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of physical therapy licensure and practice.

25. Provides the powers of the Executive Board as follows:
    a. Be comprised of nine members:
        i. Seven voting members who are elected by the Commission from the current membership of the Commission;
        ii. One ex-officio, nonvoting member from the recognized national physical therapy professional association; and
        iii. One ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.
    b. The ex-officio members will be selected by their respective organizations;
    c. The Commission may remove any member of the Executive Board as provided in bylaws;
    d. The Executive Board must meet at least annually;
    e. The Executive Board must have the following duties and responsibilities:
        i. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact legislation, fees paid by Compact member states such as annual dues, and any Commission Compact fee charged to licensees for the Compact privilege;
        ii. Ensure Compact administration services are appropriately provided, contractual or otherwise;
        iii. Prepare and recommend the budget;
        iv. Maintain financial records on behalf of the Commission;
        v. Monitor Compact compliance of member states and provide compliance reports to the Commission;
        vi. Establish additional committees as necessary; and
        vii. Other duties as provided in rules or bylaws.

26. Specifies how Commission meetings are organized as follows:

a. All meetings must be open to the public, and public notice of meetings must be given in the same manner as under the rulemaking provisions;
b. The Commission, Executive Board or other committees of the Commission may convene in a closed, non-public meeting if the Commission, Executive Board or other committees of the Commission discuss:
   i. Non-compliance of a member state with its obligations under the Compact;
   ii. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
   iii. Current, threatened or reasonably anticipated litigation;
   iv. Negotiation of contracts for the purchase, lease, sale of goods, services or real estate;
   v. Accusing any person of a crime or formally censuring any person;
   vi. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
   vii. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy, investigative records compiled for law enforcement purposes and information related to any investigative reports prepared by, or on behalf of, or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact; and
   viii. Matters specifically exempted from disclosure by federal or member state statute.
c. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision; and
d. The Commission must keep minutes that fully and clearly describe all matters discussed in a meeting and must provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action must be identified in such minutes. All minutes and documents of a closed meeting must remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

27. Provides for financing of the Commission as follows:
a. The Commission must pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities;
b. The Commission may accept any and all appropriate revenue sources, donations, grants of money, equipment, supplies, materials and services;
c. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based upon a formula to be determined by the Commission, which must promulgate a rule biding upon all member states;
d. The Commission must not incur obligations of any kind prior to securing the funds adequate to meet the same; nor should the Commission pledge the credit of any of the member states, except by and with the authority of the member state; and
e. The Commission must keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission must be subject to the audit and

accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become a part of the annual report of the Commission.

28. Stipulates qualified immunity, defense and indemnification as follows:
    a. The members, officers, executive director, employees and representatives of the Commission must be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that nothing must be construed to protect any such person from suit and/or liability for any damages, loss, injury or liability caused by the intentional or wilful or wanton misconduct of that person;
    b. The Commission must defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing should be construed to prohibit that person from retaining his or her own counsel, and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or wilful or wanton misconduct; and
    c. The Commission must indemnify and hold harmless any member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional or wilful or wanton misconduct of that person.

Data System

29. Requires the Commission to provide for the development, maintenance and utilization of a coordinated database and reporting system containing licensure, adverse action and investigative information on all licensed individuals in member states.

30. Directs a member state to submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:
    a. Identifying information;
    b. Licensure data;
    c. Adverse actions against a license or Compact privilege;
    d. Non-confidential information related to alternative program participation;
    e. Any denial of application for licensure, and the reason(s) for such denial; and
    f. Other information that may facilitate the administration of this Compact as determined by the rules of the Commission.

31. States that investigative information pertaining to a licensee in any member state will only be available to other party states.

32. Requires the Commission to promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state will be available to any other member state.
33. Permits a member state contributing information to the data system to designate information that may not be shared with the public without the express permission of the contributing state.
34. Requires any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information to be removed from the data system.

Rulemaking

35. Mandates the Commission to exercise its rulemaking powers pursuant to the rules adopted. Rules and amendments must become binding as of the date specified in each rule or amendment.
36. States that if a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four years of the date of adoption of the rule, then such rule must have no further force and effect in any member state.
37. Clarifies that rules or amendments to the rules must be adopted at a regular or special meeting of the Commission.
38. Specifies that prior to promulgation and adoption of a final rule or rules by the Commission, and at least thirty days in advance of the meeting at which the rule will be considered and voted upon, the Commission must file a Notice of Proposed Rulemaking as follows:
    a. On the website of the Commission or other publicly accessible platform; and
    b. On the website of each member state physical therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.
39. Stipulates the Notice of Proposed Rulemaking must include:
    a. The proposed time, date and location of the meeting in which the rule will be considered and voted upon;
    b. The text of the proposed rule or amendment and the reason for the proposed rule;
    c. A request for comments on the proposed rule from any interested person; and
    d. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing, and any written comments.
40. Mandates the Commission allow persons to submit written data, facts, opinions and arguments that must be made available to the public.
41. Requires the Commission to grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:
    a. At least 25 persons;
    b. A state or federal governmental subdivision or agency; or
    c. An association having at least 25 members.
42. Clarifies that if a hearing is held on the proposed rule or amendment, the Commission must publish the place, time and date of the scheduled public hearing. If the hearing is held via

electronic means, the Commission must publish the mechanism for access to the electronic hearing as follows:

a. All persons wishing to be heard at the hearing must notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing no less than five business days before the scheduled date of the hearing;
b. Hearings must be conducted in a manner that provides each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing;
c. All hearings will be recorded. A copy of the recording will be made available upon request; and
d. Nothing must be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at the hearings.

43. Requires the Commission to consider all written and oral comments received following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held.

44. Allows the Commission to proceed with promulgation of the proposed rule without a public hearing if no written notice of intent to attend the public hearing by interested parties is received.

45. Mandates the Commission, by a majority vote of all members, to take final action on the proposed rule and determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

46. Permits the Commission, upon the determination that an emergency exists, to consider and adopt an emergency rule without prior notice, opportunity for comment or hearing provided that the usual rulemaking procedures provided in the Compact must be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:
    a. Meet an imminent threat to public health, safety or welfare;
    b. Prevent a loss of Commission or member state funds;
    c. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or
    d. Protect public health and safety.

47. Allows for the Commission or an authorized committee of the Commission to direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions must be posted on the website of the Commission. The revision must be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

Oversight, Dispute Resolution, and Enforcement

48. Outlines oversight requirements as follows:
    a. The executive, legislative and judicial branches of state government in each member state must enforce this Compact and take all actions necessary and appropriate to effectuate

the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder must have standing as statutory law;

b. All courts must take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers; and

c. The Commission must be entitled to receive service of process in any such proceeding and must have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission must render a judgment or order void as to the Commission, this Compact or promulgated rules.

49. Stipulates default, technical assistance and termination as follows:

a. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission must:

i. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

ii. Provide remedial training and specific technical assistance regarding the default.

b. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

c. Termination of membership in the Compact must be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate must be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature and each of the member states;

d. A state that has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination;

e. The Commission must not bear any costs related to a state that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state; and

f. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the Federal District where the Commission has its principal offices. The prevailing member must be awarded all costs of such litigation, including reasonable attorney's fees.

50. Provides dispute resolution requirements:

a. Upon request by a member state, the Commission must attempt to resolve disputes related to the Compact that arise among member states and between member and non-member states; and

b. The Commission must promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

51. States enforcement provisions as follows:

a. The Commission, in the reasonable exercise of its discretion, must enforce the provisions and rules of this Compact;

b. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the Federal District where the Commission has its

principal offices against a member state in default to enforce compliance with the provisions of the Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member must be awarded all costs of such litigation, including reasonable attorney's fees; and

c. The remedies herein must not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

Date of Implementation of the Interstate Commission for Physical Therapy Practice and Associated Rules, Withdrawal and Amendment

52. Requires the Compact to go into effect on the date on which the Compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, must be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission must meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

53. Mandates any state that joins the Compact subsequent to the Commission's initial adoption of the rules be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission must have the full force and effect of law on the day the Compact becomes law in that state.

54. Provides withdrawal requirements as follows:
    a. A member state's withdrawal must not take effect until sixmonths after enactment of the repealing statute; and
    b. Withdrawal must not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

55. States that nothing contained in this Compact must be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.

56. Permits the Compact to be amended by the member states. No amendment to this Compact must become effective and binding upon any member state until it has enacted into the laws of all member states.

Construction and Severability

57. Stipulates the Compact to be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact must be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance must not be affected thereby. If this Compact must be held contrary to the constitution of any party state, the Compact must remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

Miscellaneous

58. Defines terms.

CURRENT LAW

Contained within Title 32, Chapter 19 are the laws relating to the practice of physical therapy. Included therein are education and licensing requirements and applicable regulations.

ADDITIONAL INFORMATION

The Federation of State Boards of Physical Therapy has launched a project to develop Compact with the purpose to increase consumer access to physical therapy services by reducing regulatory barriers to interstate mobility and cross-state practice Physical Therapy Licensure Compact.

Fifty-second Legislature
Second Regular Session

Health
H.B. 2504

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2504

(Reference to printed bill)

Strike everything after the enacting clause and insert:

"Section 1. Title 32, chapter 19, article 3, Arizona Revised Statutes, is amended by adding section 32-2053, to read:

32-2053. Physical therapy licensure compact

THE PHYSICAL THERAPY LICENSURE COMPACT IS ADOPTED AND ENACTED INTO LAW AS FOLLOWS:

SECTION 1

PURPOSE

THE PURPOSE OF THIS COMPACT IS TO FACILITATE THE INTERSTATE PRACTICE OF PHYSICAL THERAPY WITH THE GOAL OF IMPROVING PUBLIC ACCESS TO PHYSICAL THERAPY SERVICES. THE PRACTICE OF PHYSICAL THERAPY OCCURS IN THE STATE WHERE THE PATIENT/CLIENT IS LOCATED AT THE TIME OF THE PATIENT/CLIENT ENCOUNTER. THIS COMPACT PRESERVES THE REGULATORY AUTHORITY OF STATES TO PROTECT THE PUBLIC HEALTH AND SAFETY THROUGH THE CURRENT SYSTEM OF STATE LICENSURE. THIS COMPACT IS DESIGNED TO ACHIEVE THE FOLLOWING OBJECTIVES:

1. INCREASE PUBLIC ACCESS TO PHYSICAL THERAPY SERVICES BY PROVIDING FOR THE MUTUAL RECOGNITION OF OTHER MEMBER STATE LICENSES.

2. ENHANCE THE STATES' ABILITY TO PROTECT THE PUBLIC HEALTH AND SAFETY.

3. ENCOURAGE THE COOPERATION OF MEMBER STATES IN REGULATING MULTISTATE PHYSICAL THERAPY PRACTICE.

4. SUPPORT SPOUSES OF RELOCATING MILITARY MEMBERS.

Attachment 21

Adopted ✓ # of Verbals _____

Failed _____ Withdrawn _____

Not Offered _____ Analysts Initials _____

5. ENHANCE THE EXCHANGE OF LICENSURE, INVESTIGATIVE AND DISCIPLINARY INFORMATION BETWEEN MEMBER STATES.

6. ALLOW A REMOTE STATE TO HOLD A PROVIDER OF SERVICES WITH A COMPACT PRIVILEGE IN THAT STATE ACCOUNTABLE TO THAT STATE'S PRACTICE STANDARDS.

SECTION 2

DEFINITIONS

AS USED IN THIS COMPACT, AND EXCEPT AS OTHERWISE PROVIDED, THE FOLLOWING DEFINITIONS SHALL APPLY:

1. "ACTIVE DUTY MILITARY" MEANS FULL-TIME DUTY STATUS IN THE ACTIVE UNIFORMED SERVICE OF THE UNITED STATES, INCLUDING MEMBERS OF THE NATIONAL GUARD AND RESERVE ON ACTIVE DUTY ORDERS PURSUANT TO 10 UNITED STATES CODE SECTION 1211.

2. "ADVERSE ACTION" MEANS DISCIPLINARY ACTION TAKEN BY A PHYSICAL THERAPY LICENSING BOARD BASED ON MISCONDUCT OR UNACCEPTABLE PERFORMANCE, OR BOTH.

3. "ALTERNATIVE PROGRAM" MEANS A NONDISCIPLINARY MONITORING OR PRACTICE REMEDIATION PROCESS APPROVED BY A PHYSICAL THERAPY LICENSING BOARD, INCLUDING A PROGRAM RELATING TO SUBSTANCE ABUSE ISSUES.

4. "COMPACT PRIVILEGE" MEANS THE AUTHORIZATION GRANTED BY A REMOTE STATE TO ALLOW A LICENSEE FROM ANOTHER MEMBER STATE TO PRACTICE AS A PHYSICAL THERAPIST OR WORK AS A PHYSICAL THERAPIST ASSISTANT IN THE REMOTE STATE UNDER ITS LAWS AND RULES. THE PRACTICE OF PHYSICAL THERAPY OCCURS IN THE MEMBER STATE WHERE THE PATIENT/CLIENT IS LOCATED AT THE TIME OF THE PATIENT/CLIENT ENCOUNTER.

5. "CONTINUING COMPETENCE" MEANS A REQUIREMENT, AS A CONDITION OF LICENSE RENEWAL, TO PROVIDE EVIDENCE OF PARTICIPATION IN OR COMPLETION OF EDUCATIONAL AND PROFESSIONAL ACTIVITIES RELEVANT TO THE PRACTICE OR AREA OF WORK.

6. "DATA SYSTEM" MEANS A REPOSITORY OF INFORMATION ABOUT LICENSEES, INCLUDING EXAMINATION, LICENSURE, INVESTIGATIVE INFORMATION, COMPACT PRIVILEGE AND ADVERSE ACTION.

7. "ENCUMBERED LICENSE" MEANS A LICENSE THAT A PHYSICAL THERAPY LICENSING BOARD HAS LIMITED IN ANY WAY.

8. "EXECUTIVE BOARD" MEANS A GROUP OF DIRECTORS ELECTED OR APPOINTED TO ACT ON BEHALF OF, AND WITHIN THE POWERS GRANTED BY, THE COMMISSION.

9. "HOME STATE" MEANS THE MEMBER STATE THAT IS THE LICENSE'S PRIMARY STATE OF RESIDENCE.

10. "INVESTIGATIVE INFORMATION" MEANS INFORMATION, RECORDS AND DOCUMENTS RECEIVED OR GENERATED BY A PHYSICAL THERAPY LICENSING BOARD PURSUANT TO AN INVESTIGATION.

11. "JURISPRUDENCE REQUIREMENT" MEANS THE ASSESSMENT OF AN INDIVIDUAL'S KNOWLEDGE OF THE LAWS AND RULES GOVERNING THE PRACTICE OF PHYSICAL THERAPY IN A STATE.

12. "LICENSEE" MEANS AN INDIVIDUAL WHO CURRENTLY HOLDS AN AUTHORIZATION FROM THE STATE TO PRACTICE AS A PHYSICAL THERAPIST OR TO WORK AS A PHYSICAL THERAPIST ASSISTANT.

13. "MEMBER STATE" MEANS A STATE THAT HAS ENACTED THE COMPACT.

14. "PARTY STATE" MEANS ANY MEMBER STATE IN WHICH A LICENSEE HOLDS A CURRENT LICENSE OR COMPACT PRIVILEGE OR IS APPLYING FOR A LICENSE OR COMPACT PRIVILEGE.

15. "PHYSICAL THERAPIST" MEANS AN INDIVIDUAL WHO IS LICENSED BY A STATE TO PRACTICE PHYSICAL THERAPY.

16. "PHYSICAL THERAPIST ASSISTANT" MEANS AN INDIVIDUAL WHO IS LICENSED OR CERTIFIED BY A STATE AND WHO ASSISTS THE PHYSICAL THERAPIST IN SELECTED COMPONENTS OF PHYSICAL THERAPY.

17. "PHYSICAL THERAPY", "PHYSICAL THERAPY PRACTICE" OR "PRACTICE OF PHYSICAL THERAPY" MEANS THE CARE AND SERVICES PROVIDED BY OR UNDER THE DIRECTION AND SUPERVISION OF A LICENSED PHYSICAL THERAPIST.

18. "PHYSICAL THERAPY COMPACT COMMISSION" OR "COMMISSION" MEANS THE NATIONAL ADMINISTRATIVE BODY WHOSE MEMBERSHIP CONSISTS OF ALL STATES THAT HAVE ENACTED THIS COMPACT.

19. "PHYSICAL THERAPY LICENSING BOARD" OR "LICENSING BOARD" MEANS THE AGENCY OF A STATE THAT IS RESPONSIBLE FOR THE LICENSING AND REGULATION OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS.

20. "REMOTE STATE" MEANS A MEMBER STATE, OTHER THAN THE HOME STATE, WHERE A LICENSEE IS EXERCISING OR SEEKING TO EXERCISE THE COMPACT PRIVILEGE.

21. "RULE" MEANS A REGULATION, PRINCIPLE OR DIRECTIVE ADOPTED BY THE COMMISSION THAT HAS THE FORCE OF LAW.

22. "STATE" MEANS ANY STATE, COMMONWEALTH, DISTRICT OR TERRITORY OF THE UNITED STATES THAT REGULATES THE PRACTICE OF PHYSICAL THERAPY.

SECTION 3

STATE PARTICIPATION IN THE COMPACT

A. TO PARTICIPATE IN THE COMPACT, A STATE MUST DO ALL OF THE FOLLOWING:

1. PARTICIPATE FULLY IN THE COMMISSION'S DATA SYSTEM, INCLUDING USING THE COMMISSION'S UNIQUE IDENTIFIER AS DEFINED IN RULES.

2. HAVE A MECHANISM IN PLACE FOR RECEIVING AND INVESTIGATING COMPLAINTS ABOUT LICENSEES.

3. NOTIFY THE COMMISSION, IN COMPLIANCE WITH THE TERMS OF THE COMPACT AND RULES, OF ANY ADVERSE ACTION OR THE AVAILABILITY OF INVESTIGATIVE INFORMATION REGARDING A LICENSEE.

4. FULLY IMPLEMENT A CRIMINAL BACKGROUND CHECK REQUIREMENT, WITHIN A TIME FRAME ESTABLISHED BY RULE, BY RECEIVING THE RESULTS OF THE FEDERAL BUREAU OF INVESTIGATION RECORD SEARCH ON CRIMINAL BACKGROUND CHECKS AND USE THE RESULTS IN MAKING LICENSURE DECISIONS.

5. COMPLY WITH THE RULES OF THE COMMISSION.

6. UTILIZE A RECOGNIZED NATIONAL EXAMINATION AS A REQUIREMENT FOR LICENSURE PURSUANT TO THE RULES OF THE COMMISSION.

7. HAVE CONTINUING COMPETENCE REQUIREMENTS AS A CONDITION FOR LICENSE RENEWAL.

B. ON ADOPTION OF THIS COMPACT, THE MEMBER STATE SHALL HAVE THE AUTHORITY TO OBTAIN BIOMETRIC-BASED INFORMATION FROM EACH PHYSICAL THERAPY LICENSURE APPLICANT AND SUBMIT THIS INFORMATION TO THE FEDERAL BUREAU OF INVESTIGATION FOR A CRIMINAL BACKGROUND CHECK IN ACCORDANCE WITH 28 UNITED STATES CODE SECTION 534 AND 42 UNITED STATES CODE SECTION 14616.

C. A MEMBER STATE SHALL GRANT THE COMPACT PRIVILEGE TO A LICENSEE HOLDING A VALID UNENCUMBERED LICENSE IN ANOTHER MEMBER STATE IN ACCORDANCE WITH THE TERMS OF THE COMPACT AND RULES.

D. MEMBER STATES MAY CHARGE A FEE FOR GRANTING A COMPACT PRIVILEGE.

SECTION 4

COMPACT PRIVILEGE

A. TO EXERCISE THE COMPACT PRIVILEGE UNDER THE TERMS AND PROVISIONS OF THE COMPACT, THE LICENSEE SHALL MEET ALL OF THE FOLLOWING REQUIREMENTS:

1. HOLD A LICENSE IN THE HOME STATE.

2. HAVE NO ENCUMBRANCE ON ANY STATE LICENSE.

3. BE ELIGIBLE FOR A COMPACT PRIVILEGE IN ANY MEMBER STATE IN ACCORDANCE WITH SUBSECTIONS D, G AND H OF THIS SECTION.

4. NOT HAVE HAD ANY ADVERSE ACTION TAKEN AGAINST ANY LICENSE OR COMPACT PRIVILEGE WITHIN THE PREVIOUS TWO YEARS.

5. NOTIFY THE COMMISSION THAT THE LICENSEE IS SEEKING THE COMPACT PRIVILEGE WITHIN A REMOTE STATE OR STATES.

6. PAY ANY APPLICABLE FEES, INCLUDING ANY STATE FEE, FOR THE COMPACT PRIVILEGE.

7. MEET ANY JURISPRUDENCE REQUIREMENT ESTABLISHED BY THE REMOTE STATE OR STATES IN WHICH THE LICENSEE IS SEEKING A COMPACT PRIVILEGE.

8. REPORT TO THE COMMISSION ANY ADVERSE ACTION TAKEN BY ANY NONMEMBER STATE WITHIN THIRTY DAYS AFTER THE DATE THE ADVERSE ACTION IS TAKEN.

B. THE COMPACT PRIVILEGE IS VALID UNTIL THE EXPIRATION DATE OF THE HOME LICENSE. THE LICENSEE MUST COMPLY WITH THE REQUIREMENTS OF SUBSECTION A OF THIS SECTION TO MAINTAIN THE COMPACT PRIVILEGE IN THE REMOTE STATE.

C. A LICENSEE PROVIDING PHYSICAL THERAPY IN A REMOTE STATE UNDER THE COMPACT PRIVILEGE SHALL FUNCTION WITHIN THE LAWS AND REGULATIONS OF THE REMOTE STATE.

D. A LICENSEE PROVIDING PHYSICAL THERAPY IN A REMOTE STATE IS SUBJECT TO THAT STATE'S REGULATORY AUTHORITY. A REMOTE STATE, IN ACCORDANCE WITH DUE PROCESS AND THAT STATE'S LAWS, MAY REMOVE A LICENSEE'S COMPACT PRIVILEGE IN THE REMOTE STATE FOR A SPECIFIC PERIOD OF TIME, IMPOSE FINES OR TAKE ANY OTHER NECESSARY ACTIONS TO PROTECT THE HEALTH AND SAFETY OF ITS CITIZENS. THE LICENSEE IS NOT ELIGIBLE FOR A COMPACT PRIVILEGE IN ANY STATE UNTIL THE SPECIFIC TIME FOR REMOVAL HAS PASSED AND ALL FINES ARE PAID.

E. IF A HOME STATE LICENSE IS ENCUMBERED, THE LICENSEE SHALL LOSE THE COMPACT PRIVILEGE IN ANY REMOTE STATE UNTIL BOTH OF THE FOLLOWING OCCUR:

1. THE HOME STATE LICENSE IS NO LONGER ENCUMBERED.

2. TWO YEARS HAVE ELAPSED FROM THE DATE OF THE ADVERSE ACTION.

F. ONCE AN ENCUMBERED LICENSE IN THE HOME STATE IS RESTORED TO GOOD STANDING, THE LICENSEE MUST MEET THE REQUIREMENTS OF SUBSECTION A OF THIS SECTION TO OBTAIN A COMPACT PRIVILEGE IN ANY REMOTE STATE.

G. IF A LICENSEE'S COMPACT PRIVILEGE IN ANY REMOTE STATE IS REMOVED, THE INDIVIDUAL SHALL LOSE THE COMPACT PRIVILEGE IN ANY REMOTE STATE UNTIL ALL OF THE FOLLOWING OCCUR:

1. THE SPECIFIC PERIOD OF TIME FOR WHICH THE COMPACT PRIVILEGE WAS REMOVED HAS ENDED.

2. ALL FINES HAVE BEEN PAID.

3. TWO YEARS HAVE ELAPSED FROM THE DATE OF THE ADVERSE ACTION.

H. ONCE THE REQUIREMENTS OF SUBSECTION G OF THIS SECTION HAVE BEEN MET, THE LICENSE MUST MEET THE REQUIREMENTS IN SUBSECTION A OF THIS SECTION TO OBTAIN A COMPACT PRIVILEGE IN A REMOTE STATE.

SECTION 5

ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES

A LICENSEE WHO IS ACTIVE DUTY MILITARY OR IS THE SPOUSE OF AN INDIVIDUAL WHO IS ACTIVE DUTY MILITARY MAY DESIGNATE ONE OF THE FOLLOWING AS THE HOME STATE:

1. THE HOME OF RECORD.

2. THE PERMANENT CHANGE OF STATION.

3. THE STATE OF CURRENT RESIDENCE IF IT IS DIFFERENT THAN THE PERMANENT CHANGE OF STATION STATE OR HOME OF RECORD.

SECTION 6

ADVERSE ACTIONS

A. A HOME STATE SHALL HAVE EXCLUSIVE POWER TO IMPOSE AN ADVERSE ACTION AGAINST A LICENSE ISSUED BY THE HOME STATE.

B. A HOME STATE MAY TAKE AN ADVERSE ACTION BASED ON THE INVESTIGATIVE INFORMATION OF A REMOTE STATE, SO LONG AS THE HOME STATE FOLLOWS ITS OWN PROCEDURES FOR IMPOSING AN ADVERSE ACTION.

C. NOTHING IN THIS COMPACT SHALL OVERRIDE A MEMBER STATE'S DECISION THAT PARTICIPATION IN AN ALTERNATIVE PROGRAM MAY BE USED IN LIEU OF ADVERSE

ACTION AND THAT SUCH PARTICIPATION SHALL REMAIN NONPUBLIC IF REQUIRED BY THE MEMBER STATE'S LAWS. MEMBER STATES MUST REQUIRE LICENSEES WHO ENTER ANY ALTERNATIVE PROGRAMS IN LIEU OF DISCIPLINE TO AGREE NOT TO PRACTICE IN ANY OTHER MEMBER STATE DURING THE TERM OF THE ALTERNATIVE PROGRAM WITHOUT PRIOR AUTHORIZATION FROM SUCH OTHER MEMBER STATE.

D. ANY MEMBER STATE MAY INVESTIGATE ACTUAL OR ALLEGED VIOLATIONS OF THE STATUTES AND RULES AUTHORIZING THE PRACTICE OF PHYSICAL THERAPY IN ANY OTHER MEMBER STATE IN WHICH A PHYSICAL THERAPIST OR PHYSICAL THERAPIST ASSISTANT HOLDS A LICENSE OR COMPACT PRIVILEGE.

E. A REMOTE STATE SHALL HAVE THE AUTHORITY TO DO ALL OF THE FOLLOWING:

1. TAKE ADVERSE ACTIONS AS SET FORTH IN SECTION 4, SUBSECTION D OF THIS COMPACT AGAINST A LICENSEE'S COMPACT PRIVILEGE IN THE STATE.

2. ISSUE SUBPOENAS FOR BOTH HEARINGS AND INVESTIGATIONS THAT REQUIRE THE ATTENDANCE AND TESTIMONY OF WITNESSES AND THE PRODUCTION OF EVIDENCE. SUBPOENAS ISSUED BY A PHYSICAL THERAPY LICENSING BOARD IN A PARTY STATE FOR THE ATTENDANCE AND TESTIMONY OF WITNESSES OR THE PRODUCTION OF EVIDENCE FROM ANOTHER PARTY STATE SHALL BE ENFORCED IN THE LATTER STATE BY ANY COURT OF COMPETENT JURISDICTION, ACCORDING TO THE PRACTICE AND PROCEDURE OF THAT COURT APPLICABLE TO SUBPOENAS ISSUED IN PROCEEDINGS PENDING BEFORE IT. THE ISSUING AUTHORITY SHALL PAY ANY WITNESS FEES, TRAVEL EXPENSES, MILEAGE AND OTHER FEES REQUIRED BY THE SERVICE STATUTES OF THE STATE WHERE THE WITNESSES OR EVIDENCE ARE LOCATED.

3. IF OTHERWISE PERMITTED BY STATE LAW, RECOVER FROM THE LICENSEE THE COSTS OF INVESTIGATIONS AND DISPOSITION OF CASES RESULTING FROM ANY ADVERSE ACTION TAKEN AGAINST THAT LICENSEE.

F. JOINT INVESTIGATIONS ARE AS FOLLOWS:

1. IN ADDITION TO THE AUTHORITY GRANTED TO A MEMBER STATE BY ITS RESPECTIVE PHYSICAL THERAPY PRACTICE ACT OR OTHER APPLICABLE STATE LAW, A MEMBER STATE MAY PARTICIPATE WITH OTHER MEMBER STATES IN JOINT INVESTIGATIONS OF LICENSEES.

2. MEMBER STATES SHALL SHARE ANY INVESTIGATIVE, LITIGATION OR COMPLIANCE MATERIALS IN FURTHERANCE OF ANY JOINT OR INDIVIDUAL INVESTIGATION INITIATED UNDER THE COMPACT.

SECTION 7

ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION

A. THE COMPACT MEMBER STATES HEREBY CREATE AND ESTABLISH A JOINT PUBLIC AGENCY KNOWN AS THE PHYSICAL THERAPY COMPACT COMMISSION TO WHICH THE FOLLOWING APPLY:

1. THE COMMISSION IS AN INSTRUMENTALITY OF THE COMPACT STATES.

2. VENUE IS PROPER AND JUDICIAL PROCEEDINGS BY OR AGAINST THE COMMISSION SHALL BE BROUGHT SOLELY AND EXCLUSIVELY IN A COURT OF COMPETENT JURISDICTION WHERE THE PRINCIPAL OFFICE OF THE COMMISSION IS LOCATED. THE COMMISSION MAY WAIVE VENUE AND JURISDICTIONAL DEFENSES TO THE EXTENT IT ADOPTS OR CONSENTS TO PARTICIPATE IN ALTERNATIVE DISPUTE RESOLUTION PROCEEDINGS.

3. NOTHING IN THIS COMPACT SHALL BE CONSTRUED TO BE A WAIVER OF SOVEREIGN IMMUNITY.

B. MEMBERSHIP, VOTING AND MEETINGS ARE AS FOLLOWS:

1. EACH MEMBER STATE SHALL HAVE AND BE LIMITED TO ONE DELEGATE SELECTED BY THAT MEMBER STATE'S LICENSING BOARD.

2. THE DELEGATE SHALL BE A CURRENT MEMBER OF THE LICENSING BOARD, WHO IS A PHYSICAL THERAPIST, PHYSICAL THERAPIST ASSISTANT OR PUBLIC MEMBER OR THE BOARD ADMINISTRATOR.

3. ANY DELEGATE MAY BE REMOVED OR SUSPENDED FROM OFFICE AS PROVIDED BY THE LAW OF THE STATE FROM WHICH THE DELEGATE IS APPOINTED.

4. THE MEMBER STATE BOARD SHALL FILL ANY VACANCY OCCURRING IN THE COMMISSION.

5. EACH DELEGATE SHALL BE ENTITLED TO ONE VOTE WITH REGARD TO THE ADOPTION OF RULES AND CREATION OF BYLAWS AND SHALL OTHERWISE HAVE AN OPPORTUNITY TO PARTICIPATE IN THE BUSINESS AND AFFAIRS OF THE COMMISSION.

6. A DELEGATE SHALL VOTE IN PERSON OR BY SUCH OTHER MEANS AS PROVIDED IN THE BYLAWS. THE BYLAWS MAY PROVIDE FOR THE DELEGATE'S PARTICIPATION IN MEETINGS BY TELEPHONE OR OTHER MEANS OF COMMUNICATION.

7. THE COMMISSION SHALL MEET AT LEAST ONCE DURING EACH CALENDAR YEAR. ADDITIONAL MEETINGS SHALL BE HELD AS SET FORTH IN THE BYLAWS.

C. THE COMMISSION SHALL HAVE THE FOLLOWING POWERS AND DUTIES:

1. ESTABLISH THE FISCAL YEAR OF THE COMMISSION.

2. ESTABLISH BYLAWS.

3. MAINTAIN ITS FINANCIAL RECORDS IN ACCORDANCE WITH THE BYLAWS.

4. MEET AND TAKE SUCH ACTIONS AS ARE CONSISTENT WITH THE PROVISIONS OF THIS COMPACT AND THE BYLAWS.

5. ADOPT UNIFORM RULES TO FACILITATE AND COORDINATE IMPLEMENTATION AND ADMINISTRATION OF THIS COMPACT. THE RULES SHALL HAVE THE FORCE AND EFFECT OF LAW AND SHALL BE BINDING IN ALL MEMBER STATES.

6. BRING AND PROSECUTE LEGAL PROCEEDINGS OR ACTIONS IN THE NAME OF THE COMMISSION, PROVIDED THAT THE STANDING OF ANY STATE PHYSICAL THERAPY LICENSING BOARD TO SUE OR BE SUED UNDER APPLICABLE LAW SHALL NOT BE AFFECTED.

7. PURCHASE AND MAINTAIN INSURANCE AND BONDS.

8. BORROW, ACCEPT OR CONTRACT FOR SERVICES OF PERSONNEL, INCLUDING EMPLOYEES OF A MEMBER STATE.

9. HIRE EMPLOYEES, ELECT OR APPOINT OFFICERS, FIX COMPENSATION, DEFINE DUTIES AND GRANT SUCH INDIVIDUALS APPROPRIATE AUTHORITY TO CARRY OUT THE PURPOSES OF THE COMPACT AND TO ESTABLISH THE COMMISSION'S PERSONNEL POLICIES AND PROGRAMS RELATING TO CONFLICTS OF INTEREST, QUALIFICATIONS OF PERSONNEL, AND OTHER RELATED PERSONNEL MATTERS.

10. ACCEPT ANY AND ALL APPROPRIATE DONATIONS AND GRANTS OF MONEY, EQUIPMENT, SUPPLIES, MATERIALS AND SERVICES, AND RECEIVE, UTILIZE AND DISPOSE OF THE SAME, IF AT ALL TIMES THE COMMISSION AVOIDS ANY APPEARANCE OF IMPROPRIETY OR CONFLICT OF INTEREST.

11. LEASE, PURCHASE, ACCEPT APPROPRIATE GIFTS OR DONATIONS OF OR OTHERWISE OWN, HOLD, IMPROVE OR USE ANY PROPERTY, REAL, PERSONAL OR MIXED. AT ALL TIMES THE COMMISSION SHALL AVOID ANY APPEARANCE OF IMPROPRIETY.

12. SELL, CONVEY, MORTGAGE, PLEDGE, LEASE, EXCHANGE, ABANDON OR OTHERWISE DISPOSE OF ANY PROPERTY, REAL, PERSONAL OR MIXED.

13. ESTABLISH A BUDGET AND MAKE EXPENDITURES.

14. BORROW MONEY.

15. APPOINT COMMITTEES, INCLUDING STANDING COMMITTEES COMPOSED OF MEMBERS, STATE REGULATORS, STATE LEGISLATORS OR THEIR REPRESENTATIVES AND

CONSUMER REPRESENTATIVES, AND SUCH OTHER INTERESTED PERSONS AS MAY BE DESIGNATED IN THIS COMPACT AND THE BYLAWS.

16. PROVIDE AND RECEIVE INFORMATION FROM, AND COOPERATE WITH, LAW ENFORCEMENT AGENCIES.

17. ESTABLISH AND ELECT AN EXECUTIVE BOARD.

18. PERFORM SUCH OTHER FUNCTIONS AS MAY BE NECESSARY OR APPROPRIATE TO ACHIEVE THE PURPOSES OF THIS COMPACT CONSISTENT WITH THE STATE REGULATION OF PHYSICAL THERAPY LICENSURE AND PRACTICE.

D. PROVISION FOR THE EXECUTIVE BOARD IS AS FOLLOWS:

1. THE EXECUTIVE BOARD SHALL HAVE THE POWER TO ACT ON BEHALF OF THE COMMISSION ACCORDING TO THE TERMS OF THIS COMPACT AND SHALL BE COMPOSED OF THE FOLLOWING NINE MEMBERS:

(a) SEVEN VOTING MEMBERS WHO ARE ELECTED BY THE COMMISSION FROM THE CURRENT MEMBERSHIP OF THE COMMISSION.

(b) ONE EX OFFICIO, NONVOTING MEMBER FROM THE RECOGNIZED NATIONAL PHYSICAL THERAPY PROFESSIONAL ASSOCIATION.

(c) ONE EX OFFICIO, NONVOTING MEMBER FROM THE RECOGNIZED MEMBERSHIP ORGANIZATION OF THE PHYSICAL THERAPY LICENSING BOARDS.

2. THE EX OFFICIO MEMBERS WILL BE SELECTED BY THEIR RESPECTIVE ORGANIZATIONS.

3. THE COMMISSION MAY REMOVE ANY MEMBER OF THE EXECUTIVE BOARD AS PROVIDED IN BYLAWS.

4. THE EXECUTIVE BOARD SHALL MEET AT LEAST ANNUALLY.

5. THE EXECUTIVE BOARD SHALL HAVE THE FOLLOWING DUTIES AND RESPONSIBILITIES:

(a) RECOMMEND TO THE ENTIRE COMMISSION CHANGES TO THE RULES OR BYLAWS, TO THIS COMPACT LEGISLATION, TO FEES PAID BY COMPACT MEMBER STATES SUCH AS ANNUAL DUES AND TO ANY COMMISSION COMPACT FEE CHARGED TO LICENSEES FOR THE COMPACT PRIVILEGE.

(b) ENSURE COMPACT ADMINISTRATION SERVICES ARE APPROPRIATELY PROVIDED, CONTRACTUAL OR OTHERWISE.

(c) PREPARE AND RECOMMEND THE BUDGET.

(d) MAINTAIN FINANCIAL RECORDS ON BEHALF OF THE COMMISSION.

(e) MONITOR COMPACT COMPLIANCE OF MEMBER STATES AND PROVIDE COMPLIANCE REPORTS TO THE COMMISSION.

(f) ESTABLISH ADDITIONAL COMMITTEES AS NECESSARY.

(g) OTHER DUTIES AS PROVIDED IN RULES OR BYLAWS.

E. MEETINGS OF THE COMMISSION ARE AS FOLLOWS:

1. ALL MEETINGS SHALL BE OPEN TO THE PUBLIC, AND PUBLIC NOTICE OF MEETINGS SHALL BE GIVEN IN THE SAME MANNER AS REQUIRED UNDER THE RULEMAKING PROVISIONS IN SECTION 9 OF THIS COMPACT.

2. THE COMMISSION OR THE EXECUTIVE BOARD OR OTHER COMMITTEES OF THE COMMISSION MAY CONVENE IN A CLOSED, NONPUBLIC MEETING IF THE COMMISSION OR EXECUTIVE BOARD OR OTHER COMMITTEES OF THE COMMISSION MUST DISCUSS ANY OF THE FOLLOWING:

(a) NONCOMPLIANCE OF A MEMBER STATE WITH ITS OBLIGATIONS UNDER THE COMPACT.

(b) THE EMPLOYMENT, COMPENSATION OR DISCIPLINE OF OR OTHER MATTERS, PRACTICES OR PROCEDURES RELATED TO SPECIFIC EMPLOYEES, OR OTHER MATTERS RELATED TO THE COMMISSION'S INTERNAL PERSONNEL PRACTICES AND PROCEDURES.

(c) CURRENT, THREATENED OR REASONABLY ANTICIPATED LITIGATION.

(d) THE NEGOTIATION OF CONTRACTS FOR THE PURCHASE, LEASE OR SALE OF GOODS, SERVICES OR REAL ESTATE.

(e) ACCUSING ANY PERSON OF A CRIME OR FORMALLY CENSURING ANY PERSON.

(f) THE DISCLOSURE OF TRADE SECRETS OR COMMERCIAL OR FINANCIAL INFORMATION THAT IS PRIVILEGED OR CONFIDENTIAL.

(g) THE DISCLOSURE OF INFORMATION OF A PERSONAL NATURE FOR WHICH DISCLOSURE WOULD CONSTITUTE A CLEARLY UNWARRANTED INVASION OF PERSONAL PRIVACY.

(h) THE DISCLOSURE OF INVESTIGATIVE RECORDS COMPILED FOR LAW ENFORCEMENT PURPOSES.

(i) THE DISCLOSURE OF INFORMATION RELATED TO ANY INVESTIGATIVE REPORT PREPARED BY OR ON BEHALF OF OR FOR USE OF THE COMMISSION OR OTHER COMMITTEE CHARGED WITH THE RESPONSIBILITY OF INVESTIGATING OR DETERMINING COMPLIANCE ISSUES PURSUANT TO THIS COMPACT.

(j) MATTERS SPECIFICALLY EXEMPT FROM DISCLOSURE BY FEDERAL OR MEMBER STATE STATUTE.

3. IF A MEETING, OR PORTION OF A MEETING, IS CLOSED PURSUANT TO THIS SECTION, THE COMMISSION'S LEGAL COUNSEL OR DESIGNEE SHALL CERTIFY THAT THE MEETING MAY BE CLOSED AND SHALL REFERENCE EACH RELEVANT EXEMPTING PROVISION.

4. THE COMMISSION SHALL KEEP MINUTES THAT FULLY AND CLEARLY DESCRIBE ALL MATTERS DISCUSSED IN A MEETING AND SHALL PROVIDE A FULL AND ACCURATE SUMMARY OF ACTIONS TAKEN, AND THE REASONS THEREFORE, INCLUDING A DESCRIPTION OF THE VIEWS EXPRESSED. ALL DOCUMENTS CONSIDERED IN CONNECTION WITH AN ACTION SHALL BE IDENTIFIED IN SUCH MINUTES. ALL MINUTES AND DOCUMENTS OF A CLOSED MEETING SHALL REMAIN UNDER SEAL, SUBJECT TO RELEASE BY A MAJORITY VOTE OF THE COMMISSION OR ORDER OF A COURT OF COMPETENT JURISDICTION.

F. FINANCING OF THE COMMISSION IS AS FOLLOWS:

1. THE COMMISSION SHALL PAY, OR PROVIDE FOR THE PAYMENT OF, THE REASONABLE EXPENSES OF ITS ESTABLISHMENT, ORGANIZATION AND ONGOING ACTIVITIES.

2. THE COMMISSION MAY ACCEPT ANY AND ALL APPROPRIATE REVENUE SOURCES, DONATIONS AND GRANTS OF MONEY, EQUIPMENT, SUPPLIES, MATERIALS AND SERVICES.

3. THE COMMISSION MAY LEVY ON AND COLLECT AN ANNUAL ASSESSMENT FROM EACH MEMBER STATE OR IMPOSE FEES ON OTHER PARTIES TO COVER THE COST OF THE OPERATIONS AND ACTIVITIES OF THE COMMISSION AND ITS STAFF, WHICH MUST BE IN A TOTAL AMOUNT SUFFICIENT TO COVER ITS ANNUAL BUDGET AS APPROVED EACH YEAR FOR WHICH REVENUE IS NOT PROVIDED BY OTHER SOURCES. THE AGGREGATE ANNUAL ASSESSMENT AMOUNT SHALL BE ALLOCATED BASED ON A FORMULA TO BE DETERMINED BY THE COMMISSION, WHICH SHALL ADOPT A RULE THAT IS BINDING ON ALL MEMBER STATES.

4. THE COMMISSION MAY NOT INCUR OBLIGATIONS OF ANY KIND BEFORE SECURING THE MONIES ADEQUATE TO MEET THOSE OBLIGATIONS, AND THE COMMISSION MAY NOT PLEDGE THE CREDIT OF ANY OF THE MEMBER STATES, EXCEPT BY AND WITH THE AUTHORITY OF THE MEMBER STATE.

5. THE COMMISSION SHALL KEEP ACCURATE ACCOUNTS OF ALL OF ITS RECEIPTS AND DISBURSEMENTS, WHICH ARE SUBJECT TO THE AUDIT AND ACCOUNTING PROCEDURES ESTABLISHED UNDER ITS BYLAWS. ALL RECEIPTS AND DISBURSEMENTS OF MONIES

HANDLED BY THE COMMISSION SHALL BE AUDITED YEARLY BY A CERTIFIED OR LICENSED PUBLIC ACCOUNTANT, AND THE REPORT OF THE AUDIT SHALL BE INCLUDED IN AND BECOME PART OF THE ANNUAL REPORT OF THE COMMISSION.

G. QUALIFIED IMMUNITY, DEFENSE AND INDEMNIFICATION PROVISIONS ARE AS FOLLOWS:

1. THE MEMBERS, OFFICERS, EXECUTIVE DIRECTOR, EMPLOYEES AND REPRESENTATIVES OF THE COMMISSION ARE IMMUNE FROM SUIT AND LIABILITY, EITHER PERSONALLY OR IN THEIR OFFICIAL CAPACITY, FOR ANY CLAIM FOR DAMAGE TO OR LOSS OF PROPERTY OR PERSONAL INJURY OR OTHER CIVIL LIABILITY CAUSED BY OR ARISING OUT OF ANY ACTUAL OR ALLEGED ACT, ERROR OR OMISSION THAT OCCURRED, OR THAT THE PERSON AGAINST WHOM THE CLAIM IS MADE HAD A REASONABLE BASIS FOR BELIEVING OCCURRED WITHIN THE SCOPE OF COMMISSION EMPLOYMENT, DUTIES OR RESPONSIBILITIES. THIS PARAGRAPH DOES NOT PROTECT ANY SUCH PERSON FROM SUIT OR LIABILITY FOR ANY DAMAGE, LOSS, INJURY OR LIABILITY CAUSED BY THE INTENTIONAL OR WILFUL OR WANTON MISCONDUCT OF THAT PERSON.

2. THE COMMISSION SHALL DEFEND ANY MEMBER, OFFICER, EXECUTIVE DIRECTOR, EMPLOYEE OR REPRESENTATIVE OF THE COMMISSION IN ANY CIVIL ACTION SEEKING TO IMPOSE LIABILITY ARISING OUT OF ANY ACTUAL OR ALLEGED ACT, ERROR OR OMISSION THAT OCCURRED WITHIN THE SCOPE OF COMMISSION EMPLOYMENT, DUTIES OR RESPONSIBILITIES, OR THAT THE PERSON AGAINST WHOM THE CLAIM IS MADE HAD A REASONABLE BASIS FOR BELIEVING OCCURRED WITHIN THE SCOPE OF COMMISSION EMPLOYMENT, DUTIES OR RESPONSIBILITIES. THIS PARAGRAPH DOES NOT PROHIBIT THAT PERSON FROM RETAINING THE PERSON'S OWN COUNSEL IF THE ACTUAL OR ALLEGED ACT, ERROR OR OMISSION DID NOT RESULT FROM THAT PERSON'S INTENTIONAL OR WILFUL OR WANTON MISCONDUCT.

3. THE COMMISSION SHALL INDEMNIFY AND HOLD HARMLESS ANY MEMBER, OFFICER, EXECUTIVE DIRECTOR, EMPLOYEE OR REPRESENTATIVE OF THE COMMISSION FOR THE AMOUNT OF ANY SETTLEMENT OR JUDGMENT OBTAINED AGAINST THAT PERSON ARISING OUT OF ANY ACTUAL OR ALLEGED ACT, ERROR OR OMISSION THAT OCCURRED WITHIN THE SCOPE OF COMMISSION EMPLOYMENT, DUTIES, OR RESPONSIBILITIES, OR THAT SUCH PERSON HAD A REASONABLE BASIS FOR BELIEVING OCCURRED WITHIN THE SCOPE OF COMMISSION EMPLOYMENT, DUTIES OR RESPONSIBILITIES IF THE ACTUAL OR ALLEGED

ACT, ERROR OR OMISSION DID NOT RESULT FROM THE INTENTIONAL OR WILFUL OR WANTON MISCONDUCT OF THAT PERSON.

SECTION 8

DATA SYSTEM

A. THE COMMISSION SHALL PROVIDE FOR THE DEVELOPMENT, MAINTENANCE AND UTILIZATION OF A COORDINATED DATABASE AND REPORTING SYSTEM CONTAINING LICENSURE, ADVERSE ACTION AND INVESTIGATIVE INFORMATION ON ALL LICENSED INDIVIDUALS IN MEMBER STATES.

B. NOTWITHSTANDING ANY OTHER PROVISION OF STATE LAW TO THE CONTRARY, A MEMBER STATE SHALL SUBMIT A UNIFORM DATA SET TO THE DATA SYSTEM ON ALL INDIVIDUALS TO WHOM THIS COMPACT APPLIES AS REQUIRED BY THE RULES OF THE COMMISSION, INCLUDING ALL OF THE FOLLOWING:

1. IDENTIFYING INFORMATION.

2. LICENSURE DATA.

3. ADVERSE ACTIONS AGAINST A LICENSE OR COMPACT PRIVILEGE.

4. NONCONFIDENTIAL INFORMATION RELATED TO ALTERNATIVE PROGRAM PARTICIPATION.

5. ANY DENIAL OF AN APPLICATION FOR LICENSURE AND THE REASON OR REASONS FOR SUCH DENIAL.

6. OTHER INFORMATION THAT MAY FACILITATE THE ADMINISTRATION OF THIS COMPACT, AS DETERMINED BY THE RULES OF THE COMMISSION.

C. INVESTIGATIVE INFORMATION PERTAINING TO A LICENSEE IN ANY MEMBER STATE WILL ONLY BE AVAILABLE TO OTHER PARTY STATES.

D. THE COMMISSION SHALL PROMPTLY NOTIFY ALL MEMBER STATES OF ANY ADVERSE ACTION TAKEN AGAINST A LICENSEE OR AN INDIVIDUAL APPLYING FOR A LICENSE. ADVERSE ACTION INFORMATION PERTAINING TO A LICENSEE IN ANY MEMBER STATE WILL BE AVAILABLE TO ANY OTHER MEMBER STATE.

E. MEMBER STATES CONTRIBUTING INFORMATION TO THE DATA SYSTEM MAY DESIGNATE INFORMATION THAT MAY NOT BE SHARED WITH THE PUBLIC WITHOUT THE EXPRESS PERMISSION OF THE CONTRIBUTING STATE.

F. ANY INFORMATION SUBMITTED TO THE DATA SYSTEM THAT IS SUBSEQUENTLY REQUIRED TO BE EXPUNGED BY THE LAWS OF THE MEMBER STATE CONTRIBUTING THE INFORMATION SHALL BE REMOVED FROM THE DATA SYSTEM.

SECTION 9

RULEMAKING

A. THE COMMISSION SHALL EXERCISE ITS RULEMAKING POWERS PURSUANT TO THE CRITERIA SET FORTH IN THIS SECTION AND THE RULES ADOPTED UNDER THIS SECTION. RULES AND AMENDMENTS BECOME BINDING AS OF THE DATE SPECIFIED IN EACH RULE OR AMENDMENT.

B. IF A MAJORITY OF THE LEGISLATURES OF THE MEMBER STATES REJECT A RULE BY ENACTMENT OF A STATUTE OR RESOLUTION IN THE SAME MANNER USED TO ADOPT THE COMPACT WITHIN FOUR YEARS AFTER THE DATE OF ADOPTION OF THE RULE, THE RULE HAS NO FURTHER FORCE AND EFFECT IN ANY MEMBER STATE.

C. RULES OR AMENDMENTS TO THE RULES SHALL BE ADOPTED AT A REGULAR OR SPECIAL MEETING OF THE COMMISSION.

D. BEFORE THE ADOPTION OF A FINAL RULE OR RULES BY THE COMMISSION, AND AT LEAST THIRTY DAYS BEFORE THE MEETING AT WHICH THE RULE WILL BE CONSIDERED AND VOTED ON, THE COMMISSION SHALL FILE A NOTICE OF PROPOSED RULEMAKING ON BOTH:

1. THE WEBSITE OF THE COMMISSION OR OTHER PUBLICLY ACCESSIBLE PLATFORM.

2. THE WEBSITE OF EACH MEMBER STATE'S PHYSICAL THERAPY LICENSING BOARD OR OTHER PUBLICLY ACCESSIBLE PLATFORM OR THE PUBLICATION IN WHICH EACH STATE WOULD OTHERWISE PUBLISH PROPOSED RULES.

E. THE NOTICE OF PROPOSED RULEMAKING SHALL INCLUDE ALL OF THE FOLLOWING:

1. THE PROPOSED TIME, DATE AND LOCATION OF THE MEETING IN WHICH THE RULE WILL BE CONSIDERED AND VOTED ON.

2. THE TEXT OF THE PROPOSED RULE OR AMENDMENT AND THE REASON FOR THE PROPOSED RULE.

3. A REQUEST FOR COMMENTS ON THE PROPOSED RULE FROM ANY INTERESTED PERSON.

4. THE MANNER IN WHICH INTERESTED PERSONS MAY SUBMIT NOTICE TO THE COMMISSION OF THEIR INTENTION TO ATTEND THE PUBLIC HEARING, AND ANY WRITTEN COMMENTS.

F. BEFORE THE ADOPTION OF A PROPOSED RULE, THE COMMISSION SHALL ALLOW PERSONS TO SUBMIT WRITTEN DATA, FACTS, OPINIONS AND ARGUMENTS, WHICH SHALL BE MADE AVAILABLE TO THE PUBLIC.

G. THE COMMISSION SHALL GRANT AN OPPORTUNITY FOR A PUBLIC HEARING BEFORE IT ADOPTS A RULE OR AMENDMENT IF A HEARING IS REQUESTED BY ANY OF THE FOLLOWING:

1. AT LEAST TWENTY-FIVE PERSONS.

2. A STATE OR FEDERAL GOVERNMENTAL SUBDIVISION OR AGENCY.

3. AN ASSOCIATION HAVING AT LEAST TWENTY-FIVE MEMBERS.

H. IF A HEARING IS HELD ON THE PROPOSED RULE OR AMENDMENT, THE COMMISSION SHALL PUBLISH THE PLACE, TIME AND DATE OF THE SCHEDULED PUBLIC HEARING. IF THE HEARING IS HELD VIA ELECTRONIC MEANS, THE COMMISSION SHALL PUBLISH THE MECHANISM FOR ACCESS TO THE ELECTRONIC HEARING. ADDITIONALLY:

1. ALL PERSONS WISHING TO BE HEARD AT THE HEARING SHALL NOTIFY THE EXECUTIVE DIRECTOR OF THE COMMISSION OR OTHER DESIGNATED MEMBER IN WRITING OF THEIR DESIRE TO APPEAR AND TESTIFY AT THE HEARING AT LEAST FIVE BUSINESS DAYS BEFORE THE SCHEDULED DATE OF THE HEARING.

2. HEARINGS SHALL BE CONDUCTED IN A MANNER PROVIDING EACH PERSON WHO WISHES TO COMMENT A FAIR AND REASONABLE OPPORTUNITY TO COMMENT ORALLY OR IN WRITING.

3. ALL HEARINGS WILL BE RECORDED. A COPY OF THE RECORDING WILL BE MADE AVAILABLE ON REQUEST.

4. THIS SECTION DOES NOT REQUIRE A SEPARATE HEARING ON EACH RULE. RULES MAY BE GROUPED FOR THE CONVENIENCE OF THE COMMISSION AT HEARINGS REQUIRED BY THIS SECTION.

I. FOLLOWING THE SCHEDULED HEARING DATE, OR BY THE CLOSE OF BUSINESS ON THE SCHEDULED HEARING DATE IF THE HEARING WAS NOT HELD, THE COMMISSION SHALL CONSIDER ALL WRITTEN AND ORAL COMMENTS RECEIVED.

J. IF NO WRITTEN NOTICE OF INTENT TO ATTEND THE PUBLIC HEARING BY INTERESTED PARTIES IS RECEIVED, THE COMMISSION MAY PROCEED WITH THE ADOPTION OF THE PROPOSED RULE WITHOUT A PUBLIC HEARING.

K. THE COMMISSION, BY MAJORITY VOTE OF ALL MEMBERS, SHALL TAKE FINAL ACTION ON THE PROPOSED RULE AND SHALL DETERMINE THE EFFECTIVE DATE OF THE RULE, IF ANY, BASED ON THE RULEMAKING RECORD AND THE FULL TEXT OF THE RULE.

L. ON A DETERMINATION THAT AN EMERGENCY EXISTS, THE COMMISSION MAY CONSIDER AND ADOPT AN EMERGENCY RULE WITHOUT PRIOR NOTICE, AN OPPORTUNITY FOR COMMENT OR A HEARING IF THE USUAL RULEMAKING PROCEDURES PROVIDED IN THE COMPACT AND IN THIS SECTION ARE RETROACTIVELY APPLIED TO THE RULE AS SOON AS REASONABLY POSSIBLE, BUT NOT LATER THAN NINETY DAYS AFTER THE EFFECTIVE DATE OF THE RULE. FOR THE PURPOSES OF THIS SUBSECTION, AN EMERGENCY RULE IS ONE THAT MUST BE ADOPTED IMMEDIATELY IN ORDER TO DO ANY OF THE FOLLOWING:

1. MEET AN IMMINENT THREAT TO PUBLIC HEALTH, SAFETY OR WELFARE.

2. PREVENT A LOSS OF COMMISSION OR MEMBER STATE FUNDS.

3. MEET A DEADLINE FOR THE ADOPTION OF AN ADMINISTRATIVE RULE THAT IS ESTABLISHED BY FEDERAL LAW OR RULE.

4. PROTECT THE PUBLIC HEALTH AND SAFETY.

M. THE COMMISSION OR AN AUTHORIZED COMMITTEE OF THE COMMISSION MAY DIRECT REVISIONS TO A PREVIOUSLY ADOPTED RULE OR AMENDMENT FOR PURPOSES OF CORRECTING TYPOGRAPHICAL ERRORS, ERRORS IN FORMAT, ERRORS IN CONSISTENCY OR GRAMMATICAL ERRORS. PUBLIC NOTICE OF ANY REVISIONS SHALL BE POSTED ON THE WEBSITE OF THE COMMISSION. THE REVISION IS SUBJECT TO CHALLENGE BY ANY PERSON FOR A PERIOD OF THIRTY DAYS AFTER POSTING. THE REVISION MAY BE CHALLENGED ONLY ON GROUNDS THAT THE REVISION RESULTS IN A MATERIAL CHANGE TO A RULE. A CHALLENGE SHALL BE MADE IN WRITING AND DELIVERED TO THE CHAIRPERSON OF THE COMMISSION BEFORE THE END OF THE NOTICE PERIOD. IF NO CHALLENGE IS MADE, THE REVISION WILL TAKE EFFECT WITHOUT FURTHER ACTION. IF THE REVISION IS CHALLENGED, THE REVISION MAY NOT TAKE EFFECT WITHOUT THE APPROVAL OF THE COMMISSION.

SECTION 10

OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT

A. OVERSIGHT OF THE COMMISSION IS AS FOLLOWS:

1. THE EXECUTIVE, LEGISLATIVE AND JUDICIAL BRANCHES OF STATE GOVERNMENT IN EACH MEMBER STATE SHALL ENFORCE THIS COMPACT AND TAKE ALL ACTIONS NECESSARY AND APPROPRIATE TO EFFECTUATE THE COMPACT'S PURPOSES AND

INTENT. THE PROVISIONS OF THIS COMPACT AND THE RULES ADOPTED UNDER THIS COMPACT HAVE STANDING AS STATUTORY LAW.

2. ALL COURTS SHALL TAKE JUDICIAL NOTICE OF THE COMPACT AND THE RULES IN ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING IN A MEMBER STATE PERTAINING TO THE SUBJECT MATTER OF THIS COMPACT THAT MAY AFFECT THE POWERS, RESPONSIBILITIES OR ACTIONS OF THE COMMISSION.

3. THE COMMISSION IS ENTITLED TO RECEIVE SERVICE OF PROCESS IN ANY SUCH PROCEEDING AND SHALL HAVE STANDING TO INTERVENE IN SUCH A PROCEEDING FOR ALL PURPOSES. FAILURE TO PROVIDE SERVICE OF PROCESS TO THE COMMISSION SHALL RENDER A JUDGMENT OR ORDER VOID AS TO THE COMMISSION, THIS COMPACT OR RULES ADOPTED UNDER THIS COMPACT.

B. DEFAULT, TECHNICAL ASSISTANCE AND TERMINATION PROVISIONS ARE AS FOLLOWS:

1. IF THE COMMISSION DETERMINES THAT A MEMBER STATE HAS DEFAULTED IN THE PERFORMANCE OF ITS OBLIGATIONS OR RESPONSIBILITIES UNDER THIS COMPACT OR RULES ADOPTED UNDER THIS COMPACT, THE COMMISSION SHALL DO BOTH OF THE FOLLOWING:

(a) PROVIDE WRITTEN NOTICE TO THE DEFAULTING STATE AND OTHER MEMBER STATES OF THE NATURE OF THE DEFAULT, THE PROPOSED MEANS OF CURING THE DEFAULT OR ANY OTHER ACTION TO BE TAKEN BY THE COMMISSION.

(b) PROVIDE REMEDIAL TRAINING AND SPECIFIC TECHNICAL ASSISTANCE REGARDING THE DEFAULT.

2. IF A STATE IN DEFAULT FAILS TO CURE THE DEFAULT, THE DEFAULTING STATE MAY BE TERMINATED FROM THE COMPACT ON AN AFFIRMATIVE VOTE OF A MAJORITY OF THE MEMBER STATES, AND ALL RIGHTS, PRIVILEGES AND BENEFITS CONFERRED BY THIS COMPACT MAY BE TERMINATED ON THE EFFECTIVE DATE OF TERMINATION. A CURE OF THE DEFAULT DOES NOT RELIEVE THE OFFENDING STATE OF OBLIGATIONS OR LIABILITIES INCURRED DURING THE PERIOD OF DEFAULT.

3. TERMINATION OF MEMBERSHIP IN THE COMPACT SHALL BE IMPOSED ONLY AFTER ALL OTHER MEANS OF SECURING COMPLIANCE HAVE BEEN EXHAUSTED. NOTICE OF INTENT TO SUSPEND OR TERMINATE SHALL BE GIVEN BY THE COMMISSION TO THE GOVERNOR, THE MAJORITY AND MINORITY LEADERS OF THE DEFAULTING STATE'S LEGISLATURE AND EACH OF THE MEMBER STATES.

4. A STATE THAT HAS BEEN TERMINATED IS RESPONSIBLE FOR ALL ASSESSMENTS, OBLIGATIONS AND LIABILITIES INCURRED THROUGH THE EFFECTIVE DATE OF TERMINATION, INCLUDING OBLIGATIONS THAT EXTEND BEYOND THE EFFECTIVE DATE OF TERMINATION.

5. THE COMMISSION MAY NOT BEAR ANY COSTS RELATED TO A STATE THAT IS FOUND TO BE IN DEFAULT OR THAT HAS BEEN TERMINATED FROM THE COMPACT, UNLESS AGREED ON IN WRITING BETWEEN THE COMMISSION AND THE DEFAULTING STATE.

6. THE DEFAULTING STATE MAY APPEAL THE ACTION OF THE COMMISSION BY PETITIONING THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA OR THE FEDERAL DISTRICT WHERE THE COMMISSION HAS ITS PRINCIPAL OFFICES. THE PREVAILING PARTY SHALL BE AWARDED ALL COSTS OF SUCH LITIGATION, INCLUDING REASONABLE ATTORNEY FEES.

C. DISPUTE RESOLUTION PROVISIONS ARE AS FOLLOWS:

1. ON REQUEST BY A MEMBER STATE, THE COMMISSION SHALL ATTEMPT TO RESOLVE DISPUTES RELATED TO THE COMPACT THAT ARISE AMONG MEMBER STATES AND BETWEEN MEMBER AND NONMEMBER STATES.

2. THE COMMISSION SHALL ADOPT A RULE PROVIDING FOR BOTH MEDIATION AND BINDING DISPUTE RESOLUTION FOR DISPUTES AS APPROPRIATE.

D. ENFORCEMENT PROVISIONS ARE AS FOLLOWS:

1. THE COMMISSION, IN THE REASONABLE EXERCISE OF ITS DISCRETION, SHALL ENFORCE THE PROVISIONS AND RULES OF THIS COMPACT.

2. BY MAJORITY VOTE, THE COMMISSION MAY INITIATE LEGAL ACTION IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA OR THE FEDERAL DISTRICT WHERE THE COMMISSION HAS ITS PRINCIPAL OFFICES AGAINST A MEMBER STATE IN DEFAULT TO ENFORCE COMPLIANCE WITH THE PROVISIONS OF THE COMPACT AND ITS ADOPTED RULES AND BYLAWS. THE RELIEF SOUGHT MAY INCLUDE BOTH INJUNCTIVE RELIEF AND DAMAGES. IF JUDICIAL ENFORCEMENT IS NECESSARY, THE PREVAILING MEMBER SHALL BE AWARDED ALL COSTS OF SUCH LITIGATION, INCLUDING REASONABLE ATTORNEY FEES.

3. THE REMEDIES IN THIS COMPACT ARE NOT THE EXCLUSIVE REMEDIES OF THE COMMISSION. THE COMMISSION MAY PURSUE ANY OTHER REMEDIES AVAILABLE UNDER FEDERAL OR STATE LAW.

SECTION 11

DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR PHYSICAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL AND AMENDMENT

A. THIS COMPACT IS EFFECTIVE ON THE DATE ON WHICH THE COMPACT STATUTE IS ENACTED INTO LAW IN THE TENTH MEMBER STATE. THE PROVISIONS, WHICH BECOME EFFECTIVE AT THAT TIME, SHALL BE LIMITED TO THE POWERS GRANTED TO THE COMMISSION RELATING TO ASSEMBLY AND THE ADOPTION OF RULES. THEREAFTER, THE COMMISSION SHALL MEET AND EXERCISE RULEMAKING POWERS NECESSARY TO THE IMPLEMENTATION AND ADMINISTRATION OF THIS COMPACT.

B. ANY STATE THAT JOINS THE COMPACT SUBSEQUENT TO THE COMMISSION'S INITIAL ADOPTION OF THE RULES IS SUBJECT TO THE RULES AS THEY EXIST ON THE DATE ON WHICH THE COMPACT BECOMES LAW IN THAT STATE. ANY RULE THAT HAS BEEN PREVIOUSLY ADOPTED BY THE COMMISSION SHALL HAVE THE FULL FORCE AND EFFECT OF LAW ON THE DAY THE COMPACT BECOMES LAW IN THAT STATE.

C. ANY MEMBER STATE MAY WITHDRAW FROM THIS COMPACT BY ENACTING A STATUTE REPEALING THE SAME:

1. A MEMBER STATE'S WITHDRAWAL SHALL NOT TAKE EFFECT UNTIL SIX MONTHS AFTER ENACTMENT OF THE REPEALING STATUTE.

2. WITHDRAWAL SHALL NOT AFFECT THE CONTINUING REQUIREMENT OF THE WITHDRAWING STATE'S PHYSICAL THERAPY LICENSING BOARD TO COMPLY WITH THE INVESTIGATIVE AND ADVERSE ACTION REPORTING REQUIREMENTS OF THIS ACT BEFORE THE EFFECTIVE DATE OF WITHDRAWAL.

D. THIS COMPACT DOES NOT INVALIDATE OR PREVENT ANY PHYSICAL THERAPY LICENSURE AGREEMENT OR OTHER COOPERATIVE ARRANGEMENT BETWEEN A MEMBER STATE AND A NONMEMBER STATE THAT DOES NOT CONFLICT WITH THE PROVISIONS OF THIS COMPACT.

E. THIS COMPACT MAY BE AMENDED BY THE MEMBER STATES. AN AMENDMENT TO THIS COMPACT DOES NOT BECOME EFFECTIVE AND BINDING ON ANY MEMBER STATE UNTIL IT IS ENACTED INTO THE LAWS OF ALL MEMBER STATES.

SECTION 12

CONSTRUCTION AND SEVERABILITY

THIS COMPACT SHALL BE LIBERALLY CONSTRUED SO AS TO EFFECTUATE THE PURPOSES THEREOF. THE PROVISIONS OF THIS COMPACT SHALL BE SEVERABLE, AND IF ANY PHRASE, CLAUSE, SENTENCE OR PROVISION OF THIS COMPACT IS DECLARED TO BE CONTRARY TO THE CONSTITUTION OF ANY PARTY STATE OR OF THE UNITED STATES OR IF THE APPLICABILITY THEREOF TO ANY GOVERNMENT, AGENCY, PERSON OR CIRCUMSTANCE IS HELD INVALID, THE VALIDITY OF THE REMAINDER OF THIS COMPACT AND THE APPLICABILITY THEREOF TO ANY GOVERNMENT, AGENCY, PERSON OR CIRCUMSTANCE SHALL NOT BE AFFECTED THEREBY. IF THIS COMPACT IS HELD CONTRARY TO THE CONSTITUTION OF ANY PARTY STATE, THE COMPACT SHALL REMAIN IN FULL FORCE AND EFFECT AS TO THE REMAINING PARTY STATES AND IN FULL FORCE AND EFFECT AS TO THE PARTY STATE AFFECTED AS TO ALL SEVERABLE MATTERS."

Amend title to conform

HEATHER CARTER

2504CARTER
02/05/2016
11:52 AM
C: MJH

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2504

DATE February 9, 2016 MOTION: dpa/SE

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer					✓
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		5	0	0	1

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 22

ARIZONA STATE LEGISLATURE

Fifty-second Legislature - Second Regular Session

COMMITTEE ATTENDANCE RECORD

COMMITTEE ON **HEALTH**

CHAIRMAN: Heather Carter VICE-CHAIRMAN: Regina Cobb

	DATE	1/12/16	1/19/16	1/26/16	2/2/16	2/9/16
	CONVENED	2:19pm	2:39 m	2:15pm	2:16pm	3:40pm
	RECESSED					
	RECONVENED					
	ADJOURNED	3:22pm	3:10	5:57pm	4:55pm	6:17pm
MEMBERS						
Mr. Boyer		✓	✓	✓	exc	✓
Mr. Friese		✓	✓	✓	✓	✓
Mr. Lawrence		✓	✓	✓	✓	✓
Mr. Meyer		✓	✓	✓	✓	✓
Mrs. Cobb, Vice-Chairman		✓	✓	✓	✓	✓
Mrs. Carter, Chairman		✓	✓	✓	✓	✓

√ Present --- Absent exc Excused

Attachment 23